

WELLFLEET INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

STUDENT HEALTH CERTIFICATE OF COVERAGE

POLICYHOLDER: CARLETON COLLEGE
(Policyholder)
POLICY NUMBER: WI2425MNSHIP30
POLICY EFFECTIVE DATE: August 15, 2024
POLICY TERMINATION DATE: August 14, 2025
STATE OF ISSUE: Minnesota

This Certificate of Coverage ("Certificate") explains the benefits available to the Insured Person under a Policy between Wellfleet Insurance Company (hereinafter referred to as "We", "Us" or "Our") and the Policyholder.

INSURING AGREEMENTS

COVERAGE: Benefits are provided to cover the expenses incurred due to a Covered Sickness or a Covered Injury which results in Covered Medical Expenses.

We will pay the benefits under the terms of the Policy in consideration of:

1. The application for the Policy; and
2. The payment of all Premiums as set forth in the Policy.

This Certificate takes effect on the Policy Effective Date at 12:00 a.m. local time at the Policyholder's address. We must receive the Policyholder's signed application and the initial Premium for it to take place.

Termination of the Certificate

This Certificate terminates on the Policy Termination Date at 11:59 p.m. local time at the Policyholder's address.

The following pages form a part of this Certificate as fully as if the signatures below were on each page.

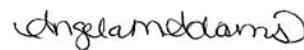
This Certificate is executed for the Company by its President and Secretary.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THIS CERTIFICATE. IT IS THE INSURED PERSON'S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

**Non-Participating
One Year Term Insurance**



President
Andrew M. DiGiorgio



Secretary
Angela Adams

Underwritten by: Wellfleet Insurance Company
5814 Reed Road, Fort Wayne, IN 46835

Administrator: Wellfleet Group, LLC
P.O. Box 15369
Springfield, MA 01115-5369
877-657-5030

NOTICE OF NON-DISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

The Company complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Company does not exclude people or treat them worse because of their race, color, national origin, age, disability, or sex.

The Company provides free aids and services to people with disabilities to communicate effectively with us, such as:

1. Qualified sign language interpreters
2. Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose first language is not English when needed to communicate effectively with us, such as:

1. Interpreters
2. information translated into other languages

If the Insured Person needs these services, contact the Civil Rights Coordinator.

If the Insured Person believes that Wellfleet Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, they can file a grievance with:

Civil Rights Coordinator
PO Box 15369, Springfield, MA 01115-5369
(413)-733-4540
civilcoordinator@wellfleetinsurance.com

The Insured Person can file a grievance in person, by mail, fax, or email. If the Insured Person needs help filing a grievance, Our Civil Rights Coordinator is available to help them. The Insured Person can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
800-868-1019; 800-537-7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

HEALTH INSURANCE REQUIREMENTS REGARDING SURPRISE MEDICAL BILLING

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

WHAT IS BALANCE BILLING (SOMETIMES CALLED SURPRISE BILLING)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plans network.

Out-of-network describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called balance billing. This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

Surprise billing is an unexpected balance bill. This can happen when you can't control who is involved in your care like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

ENDING SURPRISE AIR AMBULANCE BILLS

Air ambulance transportation that is provided to you by an out-of-network providers will be reimbursed at in-network cost sharing rates. Out-of-network air ambulance providers can't balance bill you. They can only bill you for the usual cost sharing amount set by your plan. In addition, in-network cost sharing for out-of-network services must be applied to your in-network deductible/out-of-pocket maximum.

EXTERNAL REVIEW

If you receive services from an out-of-network provider and you believe those services should have been paid at the in-network cost sharing amount, you have the right to appeal that claim. For additional information, please refer to Section X – Complaints and Appeals Procedures.

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SCHEDULE OF BENEFITS

Preventive Services:

In-Network Provider: The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of the Negotiated Charge when services are provided through an In-Network Provider.

Out-of-Network Provider: The Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through an Out-of-Network Provider. Benefits are paid at 60% of the Usual and Customary Charge.

Medical Deductible*:

Combined In-Network Provider and Out-of-Network Provider:	Individual:	\$200
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*For Covered Medical Expenses, the Medical Deductible is waived when the Insured Person is referred by the Student Health Center.

Cost sharing the Insured Person incurs for Covered Medical Expenses that is applied to the Out-of-Network Provider Deductible will be applied to satisfy the In-Network Provider Deductible. Cost sharing the Insured Person incurs for Covered Medical Expenses that is applied to the In-Network Provider Deductible will be applied to satisfy the Out-of-Network Provider Deductible.

Out-of-Pocket Maximum:

*Combined In-Network Provider and Out-of-Network Provider:	Individual:	\$7,900
	Family:	\$15,800

Cost sharing the Insured Person incurs for Covered Medical Expenses that is applied to the Out-of-Network Provider Out-of-Pocket Maximum will be applied to satisfy the In-Network Provider Out-of-Pocket Maximums and cost sharing the Insured Person incurs for Covered Medical Expenses that is applied to the In-Network Provider Out-of-Pocket Maximums will be applied to satisfy the Out-of-Network Provider Out-of-Pocket Maximum.

*The combined amount will never exceed the federal maximum.

Specialty Prescription Drug Copayment Assistance Program - Prior Authorization May Be Required.

Please note: Amounts the Insured Person pays out-of-pocket for covered Specialty Prescription Drugs will be applied towards the Deductible (if applicable) and Out-of-Pocket Maximum. Copayment Assistance may be available to the Insured Person for certain Specialty Prescription Drugs when the Insured Person's prescription is filled at a participating network pharmacy. Copayment Assistance dollars paid by the drug manufacturer for covered Specialty Prescription Drugs will not be applied towards the Deductible (if applicable) or Out-of-Pocket Maximum. Any amounts paid by the Insured Person for a covered Specialty Prescription Drug after Copayment Assistance will be applied to the deductible (if applicable) and Out-of-Pocket Maximum.

Coinsurance Amounts:

In-Network Provider:	80% of the Negotiated Charge for Covered Medical Expenses unless otherwise stated below.
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Out-of-Network Provider:	50% of the Usual and Customary Charge (U&C) for Covered Medical Expenses unless otherwise stated below.
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Student Health Center Benefits:

When Treatment is rendered at or the Insured Person is referred by the Student Health Center, the Deductible will be waived. No authorization or referral requirement will apply to obstetrical or gynecological care provided by In-Network Providers.

Medical Benefit Payments for In-Network Providers and Out-of-Network Providers

This Certificate provides benefits based on the type of health care provider the Insured Student and the Insured Student's covered Dependent selects. This Certificate provides access to both In-Network Providers and Out-of-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by In-Network Providers versus Out-of-Network Providers, as shown in the Schedule of Benefits.

When the Insured Person receives Emergency Services, or Out-of-Network air Ambulance Services, or certain non-emergency Treatment by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, the Insured Person is protected from Surprise Billing. In these situations, the Insured Person's cost sharing responsibility will be calculated as if the total amount that would be charged for the services by an In-Network Provider or facility were equal to the Recognized Amount for the services, which is generally defined either as an amount set by state law or the lesser of the billed charges and the Qualifying Payment Amount. Refer to the Preferred Provider Organization provision in the How The Plan Works And Description Of Benefits section for additional information.

How the Insured Person Can Request a Cost Estimate for Proposed Covered Services

The Insured Person may request an estimate of the costs they will have to pay when their health care provider recommends a procedure, or other covered service. The Insured Person can request this cost estimate by logging on to the www.wellfleetstudent.com website, typing in the name of the Insured Student's school and logging into the Insured Student's secure Wellfleet school webpage. Click the "Cost of Care Estimator" link and follow the steps to perform the following:

- Search for a Provider
- Request a Cost Estimate for health care services, and
- View Ratings and Reviews of Providers

The Insured Person can also print cost estimate results.

To request a cost estimate by phone, or if the Insured Person needs assistance with creating a cost estimate, call the toll-free phone number shown on the Insured Student's ID card. Wellfleet will provide the Insured Person with their cost estimate within ten (10) business days of receiving a complete cost estimate request.

Dental and Vision Benefit Payments

For dental and vision benefits, the Insured Person may choose any dental or vision provider. For dental, different benefits may be payable based on the type of service, as shown in the Schedule of Benefits.

Preferred Provider Organization

To locate an In-Network Provider in the Insured Person's area, the Insured Person should consult the Provider Directory or contact Us at the number on the Insured Student's ID card or visit Our website.

If the Insured Person incurred Covered Medical Expenses from an Out-of-Network Provider but were informed by Us prior to receipt of the Treatment that the provider was an In-Network Provider, either through the Provider Directory, or in Our response to the Insured Person's request for such information (via telephone, electronic communication, web-based or internet-based means), the Insured Person may be eligible for cost sharing that would be no greater than if the service had been provided by an In-Network Provider. For additional information, contact Us at the number on the Insured Student's ID card.

THE COVERED MEDICAL EXPENSE FOR AN ISSUED CERTIFICATE WILL BE:

- 1. THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;**
- 2. ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND**
- 3. DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY AN IN-NETWORK OR OUT-OF-NETWORK PROVIDER.**
- 4. UNLESS OTHERWISE SPECIFIED BELOW THE MEDICAL PLAN DEDUCTIBLE WILL ALWAYS APPLY.**

5. UNLESS SPECIFIED BELOW, ANY APPLICABLE COPAYMENTS ARE APPLIED AFTER DEDUCTIBLE IS MET.
6. UNLESS OTHERWISE SPECIFIED BELOW, ANY DAY OR VISIT LIMITS WILL BE APPLIED TO IN-NETWORK AND OUT-OF-NETWORK COMBINED.

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK	OUT-OF-NETWORK
INPATIENT SERVICES		
Hospital Care Includes Hospital Room and Board Expenses and Hospital Miscellaneous Expenses. Subject to Semi-Private room rate unless intensive care unit is required. Room and Board includes intensive care. Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Preadmission Testing	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physician's Visits while Confined	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Skilled Nursing Facility Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Inpatient Rehabilitation Facility Expense Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Physical Therapy while Confined (inpatient)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER BENEFITS In accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the cost sharing requirements, day or visit limits, and any Pre-certification requirements that apply to a Mental Health Disorder and Substance Use Disorder will be no more restrictive than those that apply to medical and surgical benefits for any other Covered Sickness.		
Inpatient Mental Health Disorder and Substance Use Disorder Benefit Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Outpatient Mental Health Disorder and Substance Use Disorder Benefit Physician's Office Visits including, but not limited to, Physician visits; individual and group therapy; medication management All Other Outpatient Services including, but not limited to, Intensive Outpatient Programs (IOP); partial hospitalization; Electronic Convulsive Therapy (ECT); Repetitive Transcranial Magnetic Stimulation (rTMS); Psychiatric and Neuro Psychiatric testing	90% of the Negotiated Charge after Deductible for Covered Medical Expenses 90% of the Negotiated Charge after Deductible for Covered Medical Expenses	80% of Usual and Customary Charge after Deductible for Covered Medical Expenses 80% of Usual and Customary Charge after Deductible for Covered Medical Expenses
PROFESSIONAL AND OUTPATIENT SERVICES		
<i>Surgical Expenses</i>		
Inpatient and Outpatient Surgery includes: Pre-Certification Required Surgeon Services Anesthetist Assistant Surgeon	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Surgical Facility and Miscellaneous expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Organ Transplant Surgery travel and lodging expenses a maximum of \$2,000 per Policy Year or \$250 per day, whichever is less while at the transplant facility. Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Reconstructive Surgery Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses

Other Professional Services		
Gender Affirming Treatment Benefit	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pre-Certification Required		
Home Health Care Expenses Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Home Health Care Expenses Maximum visits per Policy Year	120	120
Hospice Care Coverage	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Office Visits		
Physician's Office Visits including Specialists/Consultants	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Telehealth Services	Same as any other Physician's Office Visits including Specialists/Consultants	
Telehealth Services by a contracted Provider (Behavioral Health)	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	
Allergy Testing and Treatment, including injections	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chiropractic Care Benefit Maximum visits per Policy Year	Unlimited	30
Tuberculosis screening (TB), Titters, QuantiFERON B tests including shots (other than covered under Preventive Services)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
EMERGENCY SERVICES, AMBULANCE AND NON-EMERGENCY SERVICES		
Emergency Services in an emergency department for Emergency Medical Conditions.	\$250 Copayment per visit after Deductible then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Copayment waived if admitted	The same cost sharing requirements that apply to an In-Network Provider.
Urgent Care Centers for non-life-threatening conditions	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Emergency Ambulance Service ground and/or air, water transportation	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	The same cost sharing requirements that apply to an In-Network Provider.

Non-Emergency Ambulance Expenses ground and/or air (fixed wing) transportation Pre-Certification Required for non-emergency air Ambulance (fixed wing)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	Ground Ambulance transportation: 50% of Usual and Customary Charge after Deductible for Covered Medical Expenses Air Ambulance transportation: The same cost sharing requirements that apply to an In-Network Provider.
DIAGNOSTIC LABORATORY, TESTING AND IMAGING SERVICES		
Diagnostic Imaging Services Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
CT Scan, MRI and/or PET Scans Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Laboratory Procedures (Outpatient)	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Chemotherapy and Radiation Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infusion Therapy Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
REHABILITATION AND HABILITATION THERAPIES		
Cardiac Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Pulmonary Rehabilitation	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Rehabilitation Therapy Maximum Visits for each therapy per Policy Year for Physical Therapy, Occupational Therapy and Speech Therapy Combined with Habilitation Services Therapy The Maximum Visits do not apply to Rehabilitation Therapy for a Mental Health Disorder or Substance Use Disorder.	Unlimited	30

Habilitation Services including, Physical Therapy, and Occupational Therapy and Speech Therapy	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Habilitation Services Maximum Visits for each therapy per Policy Year for Physical Therapy, Occupational Therapy and Speech Therapy Combined with Rehabilitation Therapy The Maximum Visits do not apply to Habilitation Services for a Mental Health Disorder or Substance Use Disorder.	Unlimited	30
OTHER SERVICES AND SUPPLIES		
Covered Clinical Trials	Same as any other Covered Sickness	
Diabetic Services and Supplies (including equipment and training) Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Dialysis Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Durable Medical Equipment Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Enteral Formulas and Nutritional Supplements See the Prescription Drug section of this Schedule when purchased at a pharmacy.	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Hearing Aids (Medically Necessary) Limited to 1 hearing aid for each ear every 3 years	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Infertility Treatment Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness	

Prosthetic and Orthotic Devices Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Outpatient Private Duty Nursing Pre-Certification Required	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Student Health Center/Infirmary Expense Benefit	80% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	
Sports Accident Expense Benefit - incurred as the result of the play or practice of Intercollegiate sports or club sports Up to \$89,500 per Accident Pre-Certification not Required	Intercollegiate, or club sports payable at 100% of the Negotiated Charge up to \$500 then payable as any other Covered Injury.	Intercollegiate, or club sports payable at 100% of Usual and Customary Charge up to \$500 then payable as any other Covered Injury.
Non-emergency Care While Traveling Outside of the United States	50% of Actual Charge after Deductible for Covered Medical Expenses Subject to \$10,000 maximum per Policy Year	
Medical Evacuation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to \$50,000 maximum per Policy Year	
Repatriation Expense	100% of Actual Charge for Covered Medical Expenses Deductible Waived Subject to \$50,000 maximum per Policy Year	
PEDIATRIC AND ADULT DENTAL AND VISION CARE		
Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19) Preventive Dental Care Limited to 2 dental exams every 12 months The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care: Emergency Dental Routine Dental Care Endodontic Services	See the Pediatric Dental Care Benefit description in the Certificate for further information. 100% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses 50% of Usual and Customary Charge for Covered Medical Expenses	

Prosthodontic Services	50% of Usual and Customary Charge for Covered Medical Expenses
Periodontic Services	50% of Usual and Customary Charge for Covered Medical Expenses
Medically Necessary Orthodontic Care	50% of Usual and Customary Charge for Covered Medical Expenses
Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	Deductible Waived
Adult Dental Care Benefit (age 19 and older)	See the Adult Dental Care Benefit description in the Certificate for further information.
Preventive Dental Care Limited to 2 dental exams every 12 months	100% of Usual and Customary Charge for Covered Medical Expenses
Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	Deductible Waived
Adult Dental Care (age 19 and older) Maximum benefit per Policy Year	\$1,000
Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19)	100% of Usual and Customary Charge for Covered Medical Expenses
Limited to 1 vision examination per Policy Year and 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year	Deductible Waived
Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions.	

Adult Vision Care (age 19 and older) Routine Eye Examination once every 12 months Claim forms must be submitted to Us as soon as reasonably possible. Refer to Proof of Loss provision contained in the General Provisions	80% of Usual and Customary Charge for Covered Medical Expenses Deductible Waived	
MISCELLANEOUS DENTAL SERVICES		
Accidental Injury Dental Treatment	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Sickness Dental Expense Benefit	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	80% of the Negotiated Charge after Deductible for Covered Medical Expenses	50% of Usual and Customary Charge after Deductible for Covered Medical Expenses
Anesthesia and Hospital Charges for Dental Care	Same as any other Covered Injury, Covered Sickness or Pediatric/Adult Dental Care	
PRESCRIPTION DRUGS		
Prescription Drugs Retail Pharmacy No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy. The Insured Person’s benefit is limited to a 30 day supply. Coverage for more than a 30 day supply only applies if the smallest package size exceeds a 30 day supply. See “Retail Pharmacy Supply Limits” section for more information.		
TIER 1 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	\$20 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	\$40 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 60 day supply filled at a Retail pharmacy	\$60 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered

TIER 2 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail pharmacy See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	\$50 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	\$100 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 60 day supply filled at a Retail pharmacy	\$150 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
TIER 3 (Including Enteral Formulas) For each fill up to a 30 day supply filled at a Retail Pharmacy See the Enteral Formula and Nutritional Supplements section of this Schedule for supplements not purchased at a pharmacy.	\$70 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	\$140 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 60 day supply filled at a Retail pharmacy	\$210 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
Specialty Prescription Drugs		
For each fill up to a 30 day supply.	\$70 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered

More than a 30 day supply but less than a 61 day supply	\$140 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
More than a 60 day supply	\$210 Copayment then the plan pays 100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
Specialty Prescription Drugs with Copayment Assistance Program Copayment Assistance Program - Prior Authorization May Be Required: Amounts the Insured Person pays out-of-pocket for covered Specialty Prescription Drugs will not exceed the applicable Tier's cost share per 30 day supply and will be applied towards the Deductible (if applicable) and Out-of-Pocket Maximum. Copayment Assistance may be available to the Insured Person for certain Specialty Prescription Drugs when the Insured Person's prescription is filled at a participating network pharmacy. Visit www.wellfleetstudent.com for the applicable Specialty Prescription Drugs. Copayment Assistance dollars paid by the drug manufacturer for covered Specialty Prescription Drugs will not be applied towards the Deductible (if applicable) or Out-of-Pocket Maximum. Any amounts paid by the Insured Person for a covered Specialty Prescription Drug after Copayment Assistance will be applied to the deductible (if applicable) and Out-of-Pocket Maximum. For details, contact the Copayment Assistance Program at 636-271-5280.		
For each fill up to a 30 day supply.	75% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
Zero Cost Drugs		
	100% of the Negotiated Charge for Covered Medical Expenses Deductible Waived	Not Covered
Orally administered anti-cancer Prescription Drugs (including Specialty Drugs)		
Benefit	If the cost share for the Prescription Drug's Tier is greater than the Chemotherapy Benefit or Infusion Therapy Benefit, the cost share will be calculated as follows: Greater of: • Chemotherapy Benefit; or • Infusion Therapy Benefit The Insured Person's responsibility will not exceed the Prescription Drug Benefit.	
Diabetic Supplies (for prescription supplies purchased at a pharmacy)		
Benefit	Paid the same as any other Retail Pharmacy Prescription Drug Fill. The Insured Person's responsibility for a prescription insulin drug will not exceed the Net Price of the prescription insulin drug.	
MANDATED BENEFITS		
Cleft Lip and Cleft Palate Benefits for Dependent Children	Same as any other Covered Sickness	
Lyme Disease	Same as any other Covered Sickness	
Port-wine Stain	Same as any other Covered Sickness	
Prostate Cancer Screening	Same as any other Covered Sickness	
Routine Cancer Screenings	Same as any other Preventive Service	
PANDAS and PANS Coverage	Same as any other Covered Sickness	

Anesthesia and Hospital Charges for Dental Care	Same as any other Covered Injury, Covered Sickness, or Pediatric/Adult Dental Care
Accidental Death and Dismemberment	
Principal Sum	\$10,000
Loss must occur within 365 days of the date of a covered Accident.	
Only one benefit will be payable under this provision, that providing the largest benefit, when more than one (1) Loss occurs as the result of any one (1) Accident. This benefit is payable in addition to any other benefits payable under this Certificate.	

SECTION I - ELIGIBILITY

An Eligible Student must attend classes for at least the first 31 days of the period for which he or she is enrolled and/or pursuant to his or her Visa requirements for the period for which coverage is elected.

Except in the case of withdrawal from School due to Sickness or Injury, any student who withdraws from the Policyholder's School during the first 31 days of the period for which he or she is enrolled shall not be covered under the insurance plan. A full refund of Premium will be made, minus the cost of any claim benefits paid by the Certificate. A student who graduates or withdraws after such 31 days of the period for which he or she is enrolled will remain covered under this Certificate for the term purchased and no refund will be allowed.

A student withdrawing due to a medical withdrawal due to a Sickness or Injury, must submit documentation or certification of the medical withdrawal to Us at least 30 days prior to the medical leave of absence from the School, if the medical reason for the absence and the absence are foreseeable, or 30 days after the date of the medical leave from School. The student withdrawing due to a medical withdrawal due to a Sickness or Injury will remain covered under the Certificate for the term purchased and no refund will be allowed.

All International Students are required to have a J-1, F-1, or M-1 and their eligible Dependents (who are not U.S. citizens) are required to have a J-2, F-2, or M-2 Visa to be eligible for this insurance plan.

We maintain the right to investigate eligibility status and attendance records to verify that the Certificate eligibility requirements have been and continue to be met. If We discover that the Certificate eligibility requirements have not been met, Our only obligation is refund of Premium less any claims paid. Eligibility requirements must be met each time Premium is paid to continue coverage.

If the Insured Student or the Insured Student's Dependent has performed an act that constitutes fraud; or the Insured Student has made an intentional misrepresentation of material fact during their enrollment under this insurance plan in order to obtain coverage for a service, coverage will be terminated. We shall provide at least 30 days' advance written notice of termination to the Insured Student and/or the Insured Student's Dependent, as applicable, before coverage under this Certificate is terminated retroactively. If termination is a result of the Insured Student's action, coverage will terminate for the Insured Student and the Insured Student's Dependents. If termination is a result of the Insured Student's Dependent's action, coverage will terminate for the Insured Student's Dependent.

Who is Eligible

Class	Description of Class(es)
1	All registered Full-Time Undergraduate Domestic students and all registered International students of the Policyholder taking 6 credits.

Class 1: All students, as determined by the Policyholder, are eligible for coverage under the Policy. Eligible Students are required to have health insurance coverage and will be automatically enrolled in the Student Health Insurance Plan at registration and the Premium will be added to the student's tuition fees unless proof of comparable coverage is provided by completing the waiver.

Who is Not Eligible

Students taking distance learning, home study, correspondence, or television courses do not fulfill the eligibility requirements that the student attend classes and are not eligible to enroll in the insurance plan.

Dependent Eligibility

Dependents are eligible for coverage under this plan.

A disabled Dependent will be accepted without the application of any pre-existing condition or insurability requirements. For the purposes of this provision, a disabled Dependent is a person that is and continues to be both:

- (1) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability; and
- (2) chiefly dependent upon the Insured Student for support and maintenance.

The Insured Student's Dependent may become eligible for coverage under this Certificate only when the Insured Student becomes eligible; or within 60 days of a Qualifying Life Event.

SECTION II – EFFECTIVE AND TERMINATION DATES

Effective Dates

The Insured Student's Insurance under this Certificate will become effective on the later of:

1. The Policy Effective Date;
2. The beginning date of the term of coverage for which Premium has been paid;
3. The day after Enrollment (if applicable) and Premium payment is received by Us, Our authorized agent or the School;
4. The day after the date of postmark if the Enrollment Form is mailed; or
5. For International Students, the departure date to his or her Home Country to travel to the Country of Assignment. The scheduled arrival in the Country of Assignment must be not more than 48 hours later than the departure from the Home Country.

Dependent's coverage, becomes effective on the later of:

1. The date the Insured Student's coverage becomes effective; or
2. The date the Insured Student's Dependent is enrolled for coverage, provided Premium is paid when due.
3. The day after the date of postmark if the Enrollment Form is mailed; or
4. The beginning date of the term of coverage for which Premium has been paid; or
5. The day after the date the required individual Enrollment Form and Premium payment are received by Us or Our authorized agent. This applies only when Premium payment is made within 31 days of the Insured Student's enrollment in the School's insurance plan; or
6. The Policy Effective Date.

Grace Period

A Grace Period of 31 days will be granted for the payment of required Premiums accruing after the first Premium, during which Grace Period the Insured Person's coverage shall remain in force.

Special Enrollment – Qualifying Life Event

An eligible student, and the student's Spouse or Child can also enroll for coverage under this plan within 60 days of the loss of coverage under another health plan if coverage was terminated because the student, the student's Spouse or Child are no longer eligible for coverage under the other health plan due to:

1. Involuntary termination of the other health plan;
2. Changes in household; i.e., death in the family or getting married or divorced;
3. A Child no longer qualifies for coverage as a Child under the other health plan.

An eligible student, and the student's Spouse or Child can also enroll 60 days from exhaustion of continuation coverage under another health plan or if the Insured Student gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption.

We must receive notice and Premium payment within 60 days of the loss of coverage. The Effective Date of the Insured Person's coverage will depend on when We receive proof of the Insured Person's loss of coverage under another health plan and appropriate Premium payment. The Insured Person's coverage shall take effect on the latest of the following dates: (1) this Policy Effective Date; (2) the day after the date for which the Insured Person lost their coverage provided Premium for the Insured Person's coverage has been paid; (3) the date the Policyholder's term of coverage begins; or (4) the date the Insured Student becomes a member of an eligible class of persons.

In addition, the Insured Student, and the Insured Student's Spouse or Child can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. The Insured Student or the Insured Student's Spouse or Child loses eligibility for Medicaid or a state child health plan.
2. The Insured Student or the Insured Student's Spouse or Child becomes eligible for Medicaid or a state child health plan.

We must receive notice and Premium payment within 60 days of the loss of one of these events. The Effective Date of the Insured Person's coverage will depend on the date We receive the Insured Person's completed enrollment information and required Premium.

Termination Dates

The Insured Person's insurance will terminate on the earliest of:

1. The date this Certificate terminates; or
2. The end of the term of coverage for which Premium has been paid; or
3. The date the Insured Student ceases to be eligible for the insurance; or
4. The date the Insured Student enters military service; or
5. For International Students, the date the Insured Student ceases to meet Visa requirements; or
6. For International Students, the date the Insured Student departs the Country of Assignment for their Home Country (except for scheduled School breaks)); or
7. On any Premium due date the Policyholder fails to pay the required Premium for the Insured Student except as the result of an inadvertent error and subject to any Grace Period provision.

The Insured Student's Dependent's insurance will terminate on the earliest of:

1. The date the Insured Student's insurance ends; or
2. The date the Insured Student's Dependent ceases to be eligible for the insurance; or
3. The end of the term of coverage for which Premium has been paid.

Dependent Child Coverage

Newly Born Children

A newly born child of the Insured Person, including a grandchild who is financially dependent and living with the Insured Person continuously from the moment of birth, will be covered from the moment of birth. Such newborn child will be covered for Covered Injury or Covered Sickness. This includes the necessary care and Treatment of medically diagnosed congenital defects and birth abnormalities from the moment of birth. No notification is required as a condition of this coverage; however, if additional Premium is required to continue coverage, We shall be entitled to all Premiums that would have been collected had We been aware of the additional Dependent. We may withhold payment of any benefits for the new Dependent child until We are compensated with the applicable Premium which would have been owed if

We had been informed of the additional Dependent child immediately.

Adopted Children

Dependent Child Coverage also applies to any child adopted or placed for adoption irrespective of whether the adoption has become final. Coverage is effective from the date of placement for adoption. No notification is required as a condition of this coverage; however, if additional Premium is required to continue coverage, the Insured Person shall pay the additional Premium that would have been collected had We been aware of the additional Dependent child. We may withhold payment of any benefits for the new Dependent child until We are compensated with the applicable Premium which would have been owed if We had been informed of the additional Dependent child immediately.

As it pertains to this provision:

Child means, in connection with an adoption or placement for adoption, an individual who has not attained the age of 18 as of the date of the adoption or placement for adoption.

Placement for adoption means the assumption and retention by an Insured Person of a legal obligation for total or partial support of a child in anticipation of the adoption of a child. The child's placement with an Insured Person terminates upon the termination of the legal obligation for total or partial support.

Disabled Children

If:

1. There is Dependent coverage; and
2. This Certificate provides that coverage of a Dependent child will terminate upon attainment of a specified age, We will not terminate the coverage of such child due to attainment of that age while the child is and continues to be both:
 1. Incapable of self-sustaining employment by reason of developmental or physical disability, mental illness or disorder; and
 2. Chiefly dependent upon the Insured Student for support and maintenance.

Proof of such incapacity and dependence shall be furnished to Us within 31 days of the child's attainment of the limiting age. Upon request, We may require proof satisfactory to Us of the continuance of such incapacity and dependency. We may not request this more frequently than annually after the 2-year period following the child's attainment of the limiting age.

Extension of Benefits

Coverage under this Certificate ceases on the Termination Date of the Insured Person's insurance coverage. However, coverage for the Insured Person will be extended as follows:

1. If the Insured Person is Hospital Confined for a Covered Injury or Covered Sickness on the date their insurance coverage terminates, We will continue to pay benefits for that Covered Injury or Covered Sickness for up to 90 days from the Termination Date while such Confinement continues.

Dependents that are newly acquired during the Insured Person's Extension of Benefits period are not eligible for benefits under this provision.

Continuation of Coverage

Continuation of Coverage when Insured Student Dies

An Insured Student's covered Dependents may be able to temporarily continue coverage under this Certificate upon the death of the Insured Student.

Coverage will continue until the earliest date:

1. The date the Insured Student's coverage would have terminated under this Certificate;
2. The Dependent becomes covered by another health plan; or

3. After required Premium stops.

The request for continued coverage must be made and Premium paid within 90 days after the Insured Student's death. Premium costs may be up to 102% of the total plan costs. Written notice will be sent to the survivors last known address at least 30 days before termination of coverage due to non-payment of Premium.

Continuation of Coverage When Insured Student Enrolls in Medicare

An Insured Student's covered Dependents may be able to temporarily continue coverage under this Certificate after an Insured Student enrolls for Medicare.

Coverage will continue until the earliest date:

1. The date coverage would have terminated under this Certificate;
2. 36 months after continuation is elected;
3. The Dependent becomes covered by another health plan; or
4. Any required Premium stops.

Premium costs may be up to 102% of the total plan costs.

Continuation of Coverage When Dependent Child No Longer Qualifies for Coverage

An Insured Student's child may be able to temporarily continue coverage under this Certificate after Dependent coverage stops.

Coverage will continue until the earliest date:

1. The date coverage would have terminated under this Certificate;
2. 36 months after continuation is elected;
3. The Dependent becomes covered by another health plan; or
4. Any required Premium stops.

Premium costs may be up to 102% of the total plan costs.

This continuation of coverage provision is separate and distinct from continued coverage for a disabled Dependent child.

Continuation of Coverage Upon Divorce of an Insured Student

An Insured Student's Spouse, who was an Insured Person under this Certificate on the day before the entry of a valid decree of dissolution of marriage, and Dependent children may be able to temporarily continue coverage under this Certificate upon divorce from the Insured Student.

Coverage will continue until the earliest date:

1. The date coverage would have terminated under this Certificate;
2. The Dependent becomes covered by another health plan; or
3. After required Premium stops.

Premium costs may be up to 102% of the total plan costs.

Reinstatement Of Reservist After Release From Active Duty

If the Insured Student's insurance or an eligible Dependent's insurance ends due to the Insured Student being called or ordered to active duty, such insurance will be reinstated without any waiting period when the student returns to School and satisfies the eligibility requirements defined by the School.

Reinstatement

If We accept payment of Premium without requiring an application for reinstatement, after the time period in which the Insured Person must pay the renewal Premium, the Policy will be reinstated. If We require an application for

reinstatement of the Insured Person and issue a conditional receipt of the Premium, the Policy will be reinstated upon approval of the application, or upon 45 days following the conditional receipt of the Premium, unless We have previously notified the Insured Person, in writing, that the application was disapproved.

The reinstated Policy shall cover only loss resulting from accidental Injury sustained by the Insured Person after the date of reinstatement and loss due to such Sickness that begins more than 10 days after the date of reinstatement. Under the reinstatement Policy, We and the Insured Person shall have the same rights under the Policy immediately before the due date of the defaulted Premium, subject to any provisions in connection with the reinstatement. Any Premium accepted in connection with a reinstatement shall be applied for a period for which Premium has not been previously paid, but not to any period more than 60 days prior to the date of the reinstatement.

Refund of Premium

Refund of Premium will be considered only:

1. If a student ceases to be eligible for the insurance and coverage is terminated prior to the next Premium due date, a pro rata refund of Premium (less any claims paid) will be made for such person. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.
2. For any student who withdraws from School during the first 31 days of the period for which he or she is enrolled for a reason other than withdrawal due to Sickness or Injury. Such a student will not be covered under this Certificate and a full refund of the Premium will be made (less any claims paid) when written request is made within 90 days of withdrawal from School. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.
3. For an Insured Student entering the Armed Forces of any country. Such a student will not be covered under this Certificate as of the date of his/her entry into the service. A pro rata refund of Premium (less any claims paid) will be made upon written request received by Us within 90 days of withdrawal from School. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.
4. For an Insured International Student departing School to return to his or her Home Country on a permanent basis. We will refund a pro rata refund of Premium (less any claims paid) when written request and proof from the Policyholder that the student is no longer an eligible person is received by Us within 60 days of such departure. Insurance for the student's covered Dependent(s) will end when insurance for the student ends.

SECTION III – DEFINITIONS

These are key words used in this Certificate. They are used to describe the Policyholder's rights as well as Ours. Reference should be made to these words as the Certificate is read.

Accident means a sudden, unforeseeable external event which directly and from no other cause, results in an Injury.

Actual Charge means the charge for the Treatment by the provider who furnishes it.

Ambulance means any conveyance designed and constructed or modified and equipped to be used, maintained, or operated to transport individuals who are sick, wounded, or otherwise incapacitated.

Ambulance Service means transportation to or from a Hospital by a licensed Ambulance whether ground, air or water Ambulance, in a Medical Emergency.

Ambulatory Surgical Center means a facility which meets licensing and other legal requirements and which:

1. Is equipped and operated to provide medical care and Treatment by a Physician;
2. Does not provide services or accommodations for overnight stays, unless the expected duration of services is less than 24 hours;
3. Has a medical staff that is supervised full-time by a Physician;
4. Has full-time services of a licensed registered Nurse at all times when patients are in the facility;

5. Has at least one operating room and one recovery room and is equipped to support any surgery performed;
6. Has x-ray and laboratory diagnostic facilities;
7. Maintains a medical record for each patient; and
8. Has a written agreement with at least one Hospital for the immediate transfer of patients who develop complications or need Confinement.

Anesthetist means a Physician or Nurse who administers anesthesia during a surgical procedure. He or she may not be an employee of the Hospital where the surgical procedure is performed.

Assistant Surgeon means a Physician, or registered nurse who performs first assistant functions and services that are within the scope of practice of a registered nurse, who assists the Surgeon who actually performs a surgical procedure.

Brand-Name Prescription Drug means a Prescription Drug whose manufacture and sale is controlled by a single company as a result of a patent or similar right. Refer to the Formulary for the tier status.

Certificate: The Certificate issued by Us, including the Schedule of Benefits and any attached riders.

Coinsurance means the percentage of Covered Medical Expenses that We pay. The Coinsurance percentage is stated in the Schedule of Benefits. The Coinsurance is separate and not part of any Deductible and/or Copayment.

Complications of Pregnancy means conditions that require Hospital Confinements before the pregnancy ends and whose diagnoses are distinct from but caused or affected by pregnancy. These conditions are acute nephritis or nephrosis, cardiac decompensation, missed abortion, or similar conditions as severe as these.

Complications of Pregnancy also include non-elective cesarean section, termination of an ectopic pregnancy, and spontaneous termination when a live birth is not possible. (This does not include voluntary abortion.)

Complications of Pregnancy do not include false labor, occasional spotting or Physician prescribed rest during the period of pregnancy, morning Sickness, preeclampsia, and similar conditions not medically distinct from a difficult pregnancy.

Confinement/Confined means an uninterrupted stay following admission to a health care facility. The readmission to a health care facility for the same or related condition, within a 7 day period, will be considered a continuation of the Confinement. Confinement does not include Observation Services, which is a review or assessment of 48 hours or less, of a condition that does not result in admission to a Hospital or health care facility.

Conversion Therapy refers to any practice by a mental health practitioner or mental health professional that seeks to change an Insured Person's sexual orientation or gender identity, including efforts to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward people regardless of gender.

Conversion therapy does not include counseling that provides assistance to an Insured Person undergoing gender affirming Treatment. It also does not include counseling that provides acceptance, support, and understanding of an Insured Person or facilitates an Insured Person's coping, social support, and identity exploration and development, including sexual-orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, as long as the counseling does not seek to change the person's sexual orientation or gender identity.

Copayment means a specified dollar amount the Insured Person must pay for specified Covered Medical Expenses. Any Copayment amounts are shown in the Schedule of Benefits.

Country of Assignment means the country in which an Eligible International Student, scholar or visiting faculty member is:

1. Temporarily residing; and

2. Actively engaged in education or educational research related activities sponsored by the National Association for Foreign Student Affairs or its Member Organizations.

Covered Injury/Injury means a bodily injury due to an unforeseeable, external event which results independently of disease, bodily infirmity or any other cause. All injuries sustained in any one Accident, all related conditions and recurrent symptoms of these injuries are considered a single Injury.

Covered Medical Expense means those Medically Necessary charges for any Treatment, service, or supplies that are:

1. Not in excess of the Usual and Customary Charge therefore;
2. Not in excess of the charges that would have been made in the absence of this insurance;
3. Not in excess of the Negotiated Charge; and
4. Incurred while this Certificate is in force, except with respect to any expenses payable under the Extension of Benefits Provision.

Covered Sickness/Sickness means an illness, disease or condition, including pregnancy and Complications of Pregnancy, that impairs the Insured Person's normal function of mind or body and which is not the direct result of an Injury which results in Covered Medical Expenses. Covered Sickness includes Mental Health Disorders and Substance Use Disorders.

Custodial Care means care that is mainly for the purpose of meeting non-medical personal needs. This includes help with activities of daily living and taking medications. Activities of daily living include: bathing, dressing or grooming, eating, toileting, walking and getting in and out of bed. Custodial Care can usually be provided by someone without professional and medical skills or training.

Deductible means the dollar amount of Covered Medical Expenses the Insured Person must incur before benefits are payable under this Certificate. The amount of the Deductible, if any, will be shown in the Schedule of Benefits.

Dental Provider means any individual legally qualified to provide dental services or supplies.

Dependent means:

1. An Insured Student's lawful Spouse, civil union or lawful domestic partner;
2. An Insured Student's biological or adopted child, financially dependent grandchild who has resided continuously with the Insured Student from the moment of birth, stepchild, child who is under legal guardianship, or child covered by a court or administrative order, under age 26; and
3. An Insured Student's biological or adopted child, financially dependent grandchild who has resided continuously with the Insured Student from the moment of birth, stepchild, child who is under legal guardianship, or child covered by a court or administrative order, who has reached age 26 and who is:
 - a. primarily dependent upon the Insured Student for support and maintenance; and
 - b. incapable of self-sustaining employment by reason of developmental or physical disability, mental illness or disorder.

Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when an Insured Student enrolls a new disabled child under the plan.

Durable Medical Equipment means a device which:

1. Is primarily and customarily used for medical purposes, is specially equipped with features and functions that are generally not required in the absence of Sickness or Injury and is able to withstand repeated use;
2. Is used exclusively by the Insured Person;
3. Is not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment;
4. Is suited for use in the home;
5. Can be expected to make a meaningful contribution to treating the Insured Person's Sickness or Injury; and
6. Is prescribed by a Physician and the device is Medically Necessary for Rehabilitation.

Durable Medical Equipment does not include:

1. Comfort and convenience items;
2. Equipment that can be used by Immediate Family Members other than the Insured Person;
3. Health exercise equipment; and
4. Equipment that may increase the value of the Insured Person's residence.

Effective Date means the date coverage becomes effective.

Elective Surgery or Elective Treatment means those health care services or supplies not Medically Necessary for the care and Treatment of an Injury or Sickness. Elective surgery does not include Plastic, Cosmetic, or Reconstructive Surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.

Eligible Student means a student who meets all eligibility requirements of the School named as the Policyholder.

Emergency Medical Condition means a Sickness or Injury which manifests itself by acute symptoms which are sufficiently severe (including severe pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition: transportation services, including but not limited to Ambulance Services, a medical screening examination that is within the capability of the emergency department, including ancillary services routinely available to the emergency department, and covered inpatient and outpatient services furnished by a Hospital, independent freestanding emergency department, or Physician qualified to furnish those services that are needed to evaluate or Stabilize an Emergency Medical Condition. Coverage also includes Post-Stabilization services after the Insured Person is Stabilized. Post-Stabilization services include undergoing outpatient Observation Services, or an inpatient or outpatient stay with respect to the visit in which the other Emergency Services are furnished. The Post-Stabilization services will no longer qualify as Emergency Services once the Insured Person can travel using non-medical or non-emergency transportation and the Insured Person is in a condition to receive notice of, and to consent to, Out-of-Network Treatment.

Essential Health Benefits means benefits that are defined in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes the following categories of covered services:

1. Ambulatory patient services;
2. Emergency Services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental Health Disorder and Substance Use Disorder services, including behavioral health Treatment;
6. Prescription drugs;
7. Rehabilitation and Habilitation services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

Experimental/Investigative means the service or supply has not been demonstrated in scientifically valid clinical trials and research studies to be safe and effective for a particular indication. For further explanation, see the definition of Medically Necessary/Medical Necessity.

Formulary means a list of medications designed to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective and cost-effective medications. The Formulary indicates the type of drug and tier status.

Generic Prescription Drug means any Prescription Drug that is not a Brand-Name Prescription Drug. Refer to the Formulary for the tier status.

Habilitation Services means health care services that help the Insured Person keep, learn, or improve skills and functions for daily living. Habilitation Services may include such services as Physical Therapy, occupational therapy, and speech therapy.

Home Country means the Insured Student's country of citizenship. If the Insured Student has dual citizenship, the Insured Student's Home Country is the country of the passport they used to enter the United States. The Insured Student's Home Country is considered the Home Country for any International Dependent of the Insured Student's while insured under this Certificate.

Home Health Care Agency means an agency that:

1. Is constituted, licensed and operated under the provision of Title XVIII of the Federal Social Security Act, or qualified to be so operated if application was made, and certified by the jurisdiction in which the Home Health Care plan is established; and
2. Is engaged primarily in providing Skilled Nursing Facility services and other therapeutic services in the Insured Person's home under the supervision of a Physician or a Nurse; and
3. Maintains clinical records on all patients.

Home Health Care means the continued care and Treatment if:

1. The Insured Person's institutionalization would have been required if Home Health Care was not provided; and
2. The Insured Person's Physician establishes and approves in writing the plan of treatment covering the Home Health Care service; and
3. Home Health Care is provided by:
 - a. a Hospital that has a valid operating certificate and is certified to provide Home Health Care services; or
 - b. a public or private health service or agency that is licensed as a Home Health Care Agency under title 19, subtitle 4 of the General Health Article to provide coordinated Home Health Care.

Hospice: means a coordinated plan of home and inpatient care which treats the terminally ill patient and family as a unit. It provides care to meet the special needs of a family unit during the final stages of a terminal illness and during the bereavement. Care is provided by a team of: trained medical personnel, homemakers, and counselors. The team acts under an independent Hospice administration. It helps the family unit cope with: physical, psychological, spiritual, social, and economic stresses.

Hospital: A facility which provides diagnosis, Treatment, and care of persons who need acute inpatient Hospital care under the supervision of Physicians and provides 24-hour nursing service by Registered Nurses on duty or call. It must be licensed as a general acute care Hospital according to state and local laws. Hospital shall also include a psychiatric health facility for the Treatment of mental or psychoneurotic disorders. Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

Hospital also includes an Ambulatory Surgical Center or ambulatory medical center; and a birthing facility certified and licensed as such under the laws where located. It shall also include an Inpatient Rehabilitation Facility if such is specifically required for Treatment of physical disability.

Facilities primarily treating drug addiction or alcoholism that are licensed to provide these services are also included in this definition. Hospital does not include a place primarily for rest, the aged, a place for educational or Custodial Care or Hospice.

Immediate Family Member means the Insured Student and the Insured Student's Spouse or the parent, child, brother or sister of the Insured Student or Insured Student's Spouse.

In-Network Providers are Physicians, Hospitals and other healthcare providers who have contracted with Us to provide specific medical care at negotiated prices.

Inpatient Rehabilitation Facility means a licensed institution devoted to providing medical and nursing care over a prolonged period, such as during the course of the Rehabilitation phase after an acute Sickness or Injury.

Insured Person means an Insured Student or Dependent of an Insured Student while insured under this Certificate.

Insured Student means a student of the Policyholder who is eligible and insured for coverage under this Certificate.

International Student means an international student:

1. With a current passport and a student Visa;
2. Who is temporarily residing outside of his or her Home Country; and
3. Is actively engaged as a student or in educational research activities through the Policyholder.

In so far as this Certificate is concerned, permanent residents or those who have applied for Permanent Residency Status are not considered to be an International Student.

Loss means medical expense caused by an Injury or Sickness which is covered by this Certificate.

Medically Necessary or **Medical Necessity** means diagnostic testing and medical Treatment which is medically appropriate to the Insured Person's physical or mental diagnosis for an Injury or Sickness, and Preventive Services covered in this Certificate. Medically Necessary care must meet the following criteria:

1. Is appropriate, in terms of type, frequency, level, setting, and duration, to the Insured Person's diagnosis or condition, and diagnostic testing and preventive service; and
2. Consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or Treatment; and
3. Restores or maintains health; or
4. Prevents deterioration of the Insured Person's condition.

Mental Health Disorder means a condition or disorder that substantially limits the life activities of an Insured Person with the disorder. Mental Health Disorders must be listed as a Mental Health Disorder in the most recent version of the International Classification of Disease Manual (ICD) published by the World Health Organization.

Negotiated Charge means the amount an In-Network Provider will accept as payment in full for Covered Medical Expenses.

Net Price means Our cost for a prescription insulin drug, including any rebates or discounts received by or accrued directly or indirectly by Us from a drug manufacturer or pharmacy benefit manager.

Nurse means a licensed Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who:

1. Is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
2. Provides medical services which are within the scope of the Nurse's license or certificate who does not ordinarily reside in the Insured Person's home or is not related to the Insured Person by blood or marriage.

Observation Services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge the Insured Person. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

Organ Transplant means the moving of an organ from one (1) body to another or from a donor site to another location of the person's own body, to replace the recipient's damaged, absent or malfunctioning organ.

Out-of-Network Providers are Physicians, Hospitals and other healthcare providers who have not agreed to any pre-arranged fee schedules.

Out-of-Pocket Maximum means the most the Insured Person will incur during a Policy Year before the Insured Person's coverage begins to pay 100% of the allowed amount for Covered Medical Expenses. Refer to the Out-of-Pocket Maximum in the Description of Benefits section for details on how the Out-of-Pocket Maximum applies. This limit will never include Premium, balance-billed charges or health care this Certificate does not cover.

Physical Therapy means any form of the following:

1. Physical or mechanical therapy;
2. Diathermy;
3. Ultra-sonic therapy;
4. Heat Treatment in any form; or
5. Manipulation or massage.

Physician means a health care professional practicing within the scope of his or her license, including a Physician Assistant (PA), or Advanced Practice Nurse Practitioner (APRN), or other health care professional practicing within the scope of his or her license, and is duly licensed by the appropriate state regulatory agency to perform a particular service which is covered under this Certificate, and who is not:

1. The Insured Person;
2. An Immediate Family Member; or
3. A person employed or retained by the Insured Person.

Policy means the Student Health Insurance Policy (Policy). The Policy consists of several documents taken together.

Policy Year means the period of time measured from the Policy Effective Date to the Policy Termination Date.

Preadmission Testing means tests done in conjunction with and within 5 working days of a scheduled surgery where an operating room has been reserved before the tests are done.

Qualifying Life Event means an event that qualifies a student to apply for coverage for him/herself or for the Insured Student's Dependent due to a Qualifying Life Event under this Certificate.

Qualifying Payment Amount means the median Negotiated Charge for:

1. The same or similar services;
2. Furnished in the same or similar facility;
3. By a provider of the same or similar specialty;
4. In the same or similar geographic area.

Recognized Amount means:

- an amount determined by an All-Payer Model Agreement under the Social Security Act, if adopted by the Insured Person's state;
- if there is no applicable All-Payer Model Agreement, an amount determined by a specified state law; or
- if neither of the above apply, the lesser of:
 - a. the actual amount billed by the provider or facility; or
 - b. the Qualifying Payment Amount.

Rehabilitation means the process of restoring the Insured Person's ability to live and work after a disabling condition by:

1. Helping the Insured Person achieve the maximum possible physical and psychological fitness;
2. Helping the Insured Person regain the ability to care for themselves;
3. Offering assistance with relearning skills needed in everyday activities, with occupational training and guidance with psychological readjustment.

Rescission of Coverage means a retroactive termination of the Insured Person's coverage.

Reservist means a member of a reserve component of the Armed Forces of the United States. Reservists also includes a member of the State National Guard and the State Air National Guard.

School means the college or university attended by the Insured Student.

Skilled Nursing Facility means a facility, licensed, and operated as set forth in applicable state law, which:

1. Mainly provides inpatient care and Treatment for persons who are recovering from a Sickness or Injury;
2. Provides care supervised by a Physician;
3. Provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
4. Is not a place primarily for the care of the aged, Custodial or Domiciliary Care, or Treatment of alcohol or drug dependency; and
5. Is not a rest, educational, or custodial facility or similar place.

Sound, Natural Teeth means natural teeth. The major portion of a tooth must be present, regardless of fillings, and not carious, abscessed or defective. Sound, Natural Teeth will not include capped teeth.

Spouse means an eligible individual who is legally married to the Insured Student under the laws of the state or jurisdiction in which the marriage was performed. A Spouse also includes the Insured Student's domestic partner with whom an affidavit of domestic partnership has been established, attesting to the relationship with another person.

Stabilize/Stabilization and Post-Stabilization means, with respect to an Emergency Medical Condition, to provide such medical Treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Student Health Center/Student Infirmary means an on-campus facility or a designated facility by the Policyholder that provides:

1. Medical care and Treatment to sick or injured students; and
2. Nursing services.

A Student Health Center/Student Infirmary does not include:

1. Medical, diagnostic and Treatment facilities with major surgical facilities on its premises or available on a pre-arranged basis; or
2. Inpatient care.

Substance Use Disorder means any condition or disorder that substantially limits the life activities of an Insured Person with the disorder. Substance Use Disorders must be listed as a Substance Use Disorder in the most recent version of the International Classification of Disease Manual (ICD) published by the World Health Organization.

Surgeon means a Physician who actually performs surgical procedures.

Surprise Billing is an unexpected balance bill. This can happen when the Insured Person can't control who is involved in the Insured Person's care-like when the Insured Person has an Emergency Medical Condition or when the Insured Person schedules a visit at an In-Network Hospital or Ambulatory Surgical Center but is unexpectedly treated by an Out-of-

Network Provider.

Telehealth Services means the delivery of health care services or consultations through the use of real time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, Treatment, education, and care management of a patient's health care.

Telehealth includes:

1. the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site.
2. audio-only communication between a health care provider and a patient if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio-only communication. Substance Use Disorder Treatment services and mental health care services delivered through telehealth by means of audio-only communication may be covered without a scheduled appointment if the communication was initiated by the Insured Person while in an emergency or crisis situation and a scheduled appointment was not possible due to the need of an immediate response.

Telehealth does not include:

1. communication between health care providers that consists solely of a telephone conversation, e-mail, or facsimile transmission.
2. communication between a health care provider and a patient that consists solely of an e-mail or facsimile transmission.
3. Telemonitoring services, unless
 - a. the Telemonitoring service is medically appropriate based on the Insured Person's medical condition or status;
 - b. the Insured Person is cognitively and physically capable of operating the monitoring device or equipment, or the Insured Person has a caregiver who is willing and able to assist with the monitoring device or equipment; and
 - c. the Insured Person resides in a setting that is suitable for Telemonitoring and not in a setting that has health care staff on site.

Telemonitoring services means the remote monitoring of clinical data related to the Insured Person's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a health care provider for analysis. Telemonitoring is intended to collect an Insured Person's health-related data for the purpose of assisting a health care provider in assessing and monitoring the Insured Person's medical condition or status.

Treatment means the medical care of a Covered Injury or Covered Sickness by a Physician who is operating within the scope of his or her license. Such care includes diagnostic, medical, surgical or therapeutic services, medical advice, consultation, recommendation, and/or the taking of drugs or medicines or the prescriptions thereof.

Urgent Care means short-term medical care performed in an Urgent Care Center for non-life-threatening conditions that can be mitigated or require care within 48 hours of onset.

Urgent Care Center is a category of walk-in clinic focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional emergency department. Urgent Care Centers primarily treat non-life-threatening conditions that require immediate care but are not serious enough to require an emergency department visit.

Usual and Customary Charge is the amount of an Out-of-Network Provider's charge that is eligible for coverage. The Insured Person is responsible for all amounts above what is eligible for coverage.

The Usual and Customary Charge depends on the geographic area where the Insured Person receives the service or supply. The table below shows the method for calculating the Usual and Customary Charge for specific services or supplies:

Service or Supply	Usual and Customary Charge
Professional services and other services or supplies not mentioned below	The Reasonable amount rate
Services of Hospitals and other facilities	The Reasonable amount rate

Special terms used

- Geographic area is normally based on the first 3 digits of the U.S. Postal Service zip codes. If We determine We need more data for a particular service or supply, We may base rates on a wider geographic area such as an entire state.
- “Reasonable amount rate” means the Insured Person’s plan has established a reasonable rate amount as follows:

Service or Supply	Reasonable Amount Rate
Professional services and Inpatient and outpatient charges of Hospitals	The lesser of: 1. The billed charge for the services; or 2. An amount determined using current publicly-available data which is usual and customary when compared with the charges made for a) similar services and supplies and b) to persons having similar medical conditions in the geographic area where service is rendered; or 3. An amount based on information provided by a third-party vendor, which may reflect 1 or more of the following factors: 1) the complexity or severity of Treatment; 2) level of skill and experience required for the Treatment; or 3) comparable providers’ fees and costs to deliver care; or 4. In the case of Emergency Services from an Out-of-Network Provider or facility, and certain non-emergency Treatment by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, the Recognized Amount.

Our reimbursement policies

We reserve the right to apply Our reimbursement policies to all Out-of-Network services including involuntary services. Our reimbursement policies may affect the Usual and Customary Charge. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an Assistant Surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the provider

In some instances, We may negotiate a lower rate with Out-of-Network Providers.

Our reimbursement policies are based on Our review of:

- The Centers for Medicare and Medicaid Services’ (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate;
- Generally accepted standards of medical and dental practice;
- The views of Physicians and dentists practicing in the relevant clinical areas.

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

No payment will be made under this Certificate for any expenses incurred which, in Our judgment, are in excess of Usual and Customary Charges.

Visa means the document issued by the United States Government that permits an individual to participate in the educational activities of a college, university or other institution of higher learning either as a student or in another academic capacity. An International Student must have and maintain a valid Visa, either an F-1 (Academic), J-1 (Exchange) or M-1 (Vocational) in order to continue as a student in the United States.

We, Us, or Our means Wellfleet Insurance Company or its authorized agent. Also referred to as the Company.

SECTION IV – HOW THE PLAN WORKS AND DESCRIPTION OF BENEFITS

Schedule of Benefits

The following are shown in the Schedule of Benefits:

- Deductible;
- Any specified benefit maximums;
- Coinsurance percentages;
- Copayment amounts; and
- Out-of-Pocket Maximums.

How the Deductible Works

Medical Deductible

The Medical Deductible amount (if any) is shown in the Schedule of Benefits.

This dollar amount is what the Insured Person has to incur in Covered Medical Expenses before benefits are payable under this Certificate. This amount will apply on an individual basis. The Medical Deductible applies to all Covered Medical Expenses, unless specifically noted. Any expenses that the Insured Person incurs that are not Covered Medical Expenses are not applied toward the Insured Person's Medical Deductible.

Covered Medical Expenses applied to the In-Network Provider Medical Deductible will apply to the Out-of-Network Provider Medical Deductible. Covered Medical Expenses applied to the Out-of-Network Provider Medical Deductible will apply to the In-Network Provider Medical Deductible.

Individual

The Medical Deductible is an amount the individual must incur for In-Network Provider and Out-of-Network Provider Covered Medical Expenses before the plan pays. This Medical Deductible applies separately to the Insured Student and each of the Insured Student's covered Dependents. After the amount of Covered Medical Expenses the Insured Person incurs reaches the Medical Deductible, this plan will pay for Covered Medical Expenses as shown on the Schedule of Benefits for the rest of the Policy Year.

Coinsurance is the percentage of Covered Medical Expenses that We pay. The Coinsurance percentage is stated in the Schedule of Benefits. The Coinsurance is separate and not part of any Deductible and/or Copayment.

Copayment is a specified dollar amount the Insured Person must pay for specified Covered Medical Expenses. Any Copayment amounts are shown in the Schedule of Benefits.

How the Insured Person's Out-of-Pocket Maximum Works

The In-Network Provider and Out-of-Network Provider Out-of-Pocket Maximums are shown in the Schedule of Benefits. The Out-of-Pocket Maximum is the amount of Covered Medical Expenses the Insured Person has to incur before Covered

Medical Expense will be paid at 100% for the remainder of the Policy Year, subject to any benefit maximums or limits that may apply. Any applicable Coinsurance amounts, Deductibles, and Copayments will apply toward the Out-of-Pocket Maximum.

Services that are not Covered Medical Expenses balance-billed charges, and Premium do not count toward meeting the Out-of-Pocket Maximum.

Covered Medical Expenses applied to the In-Network Provider Out-of-Pocket Maximums will be applied to satisfy the Out-of-Network Provider Out-of-Pocket Maximum and Covered Medical Expenses applied to the Out-of-Network Provider Out-of-Pocket Maximum will be applied to satisfy the In-Network Provider Out-of-Pocket Maximums.

The Out-of-Pocket Maximum is the maximum amount of Covered Medical Expenses the Insured Person will incur for Copayments, Coinsurance, and Deductibles during the Policy Year. This plan has an individual and family Out-of-Pocket Maximum. As to the individual Out-of-Pocket Maximum, each Insured Person must meet their Out-of-Pocket Maximum separately.

Individual

Once the amount of the Copayments, Coinsurance, and Deductibles the Insured Student and the Insured Student's covered Dependents have incurred for Covered Medical Expenses during the Policy Year meets the:

- In-Network Provider individual Out-of-Pocket Maximum, this plan will pay:
 - 100% of the Negotiated Charge for In-Network Provider Covered Medical Expenses
- Out-of-Network Provider individual Out-of-Pocket Maximum, this plan will pay:
 - 100% of the Usual and Customary Charge for Out-of-Network Covered Medical Expenses

that apply towards the limits for the rest of the Policy Year for that covered individual.

Family

Once the amount of the Copayments, Coinsurance, and Deductibles the Insured Student and the Insured Student's covered Dependents have incurred for Covered Medical Expenses during the Policy Year meets the:

- In-Network Provider family Out-of-Pocket Maximum, this plan will pay:
 - 100% of the Negotiated Charge for In-Network Provider Covered Medical Expenses
- Out-of-Network Provider family Out-of-Pocket Maximum, this plan will pay:
 - 100% of the Usual and Customary for Out-of-Network Covered Medical Expenses

that apply towards the limits for the rest of the Policy Year for all covered family members.

To satisfy this family Out-of-Pocket Maximum for the rest of the Policy Year, the following must happen:

- The family Out-of-Pocket Maximum is a cumulative Out-of-Pocket Maximum for all covered family members. The family Out-of-Pocket Maximum can be met by a combination of covered family members with no single individual within the family contributing more than the individual Out-of-Pocket Maximum amount in a Policy Year.

The Out-of-Pocket Maximum is the maximum amount of Covered Medical Expenses the Insured Person is responsible to incur during the Policy Year. This plan has an individual and family Out-of-Pocket Maximum.

Essential Health Benefits

Essential Health Benefits are not subject to annual or lifetime dollar limits. If additional specific care, Treatment or services are added to the list of Essential Health Benefits by a governing authority, the Certificate benefits will be amended to comply with such changes.

Treatment of Covered Injury and Covered Sickness Benefit

If:

1. The Insured Person incurs expenses as the result of Covered Injury or Covered Sickness, then
2. We will pay the benefits stated in the Schedule of Benefits for the services, Treatments, and supplies described in

the Covered Medical Expenses provision below.

Payment will be made, subject to the Coinsurance, Deductible, Copayment, maximums, and limits as stated in the Schedule of Benefits:

1. For the Negotiated Charge at an In-Network Provider or the Usual and Customary Charge at an Out-of-Network Provider for Covered Medical Expenses that are incurred as the result of a Covered Injury or Covered Sickness; and
2. Subject to the Exclusions and Limitations provision.

Medical Benefit Payments for In-Network Provider and Out-of-Network Providers

This Certificate provides benefits based on the type of health care provider the Insured Student and the Insured Student's covered Dependent selects. This Certificate provides access to both In-Network Providers and Out-of-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by In-Network Providers versus Out-of-Network Providers, as shown in the Schedule of Benefits.

Dental and Vision Benefit Payments

For dental and vision benefits, the Insured Person may choose any dental or vision provider.

For dental, different benefits may be payable based on type of service, as shown in the Schedule of Benefits.

Preferred Provider Organization

If the Insured Person uses an In-Network Provider, this Certificate will pay the Coinsurance percentage of the Negotiated Charge for Covered Medical Expenses shown in the Schedule of Benefits.

If an Out-of-Network Provider is used, this Certificate will pay the Coinsurance percentage of the Usual and Customary Charge for Covered Medical Expenses shown in the Schedule of Benefits. The difference between the provider fee and the Coinsurance amount paid by Us will be the Insured Person's responsibility.

Note, however, that We will pay at the In-Network level for Treatment by an Out-of-Network Provider, and will calculate the Insured Person's cost sharing amount at the In-Network Provider level, and the Insured Person's cost share will be applied to their In-Network Deductible and Out-of-Pocket Maximum if:

1. there is no In-Network Provider in the Preferred Provider service area available to provide a Preventive Service or treat the Insured Person for a specific Covered Injury or Covered Sickness; or
2. The Insured Person has an Emergency Medical Condition and receives Emergency Services from an Out-of-Network Provider or facility. The most the Out-of-Network Provider or facility may bill the Insured Person is the In-Network cost sharing amount (such as Deductibles, Copayments and Coinsurance). The Insured Person can't be balance billed for these Emergency Services. This includes services the Insured Person may get after they're in stable condition, unless the Out-of-Network Provider or facility determines that the Insured Person can travel using non-medical or non-emergency transportation, the Out-of-Network Provider satisfies the consent and notice requirements, and the Insured Person is in a condition to receive notice of, and to consent to, Out-of-Network Treatment; or
3. The Insured Person receives non-Emergency Services from an In-Network Hospital or Ambulatory Surgical Center as described in the Unauthorized Provider Services provision.

However, if the Insured Person received notice from the Out-of-Network Provider of their non-network status at least 72 hours in advance, or if the Insured Person makes an appointment within 72 hours of the services being delivered and notice and consent is given on the date of the service, and the Insured Person gave written consent to Treatment, this Certificate will pay Covered Medical Expenses at the Out-of-Network level as shown in the Schedule of Benefits. This notice and consent exception does not apply to ancillary services, which include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner; items and services provided by Assistant Surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and

services provided by an Out-of-Network Provider in circumstances where there is no In-Network Provider who can furnish the item or service at the relevant facility.

The Insured Person should be aware that In-Network Hospitals may be staffed with Out-of-Network Providers. Receiving services from an In-Network Hospital does not guarantee that all charges will be paid at the In-Network Provider level of benefits. It is important that the Insured Person verify that their Physicians are In-Network Providers each time they call for an appointment or at the time of service.

Unauthorized Provider Services Required by the No Surprises Act

- A. Unauthorized provider services occur when an Insured Person receives services:
- (1) From an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, when the services are rendered:
 - (a) due to the unavailability of an In-Network Provider;
 - (b) by an Out-of-Network Provider without the Insured Person's knowledge; or
 - (c) due to the need for unforeseen services arising at the time the services are being rendered; or
 - (2) From an In-Network Provider that sends a specimen taken from the Insured Person in the In-Network Provider's practice setting to an Out-of-Network laboratory, pathologist, or other medical testing facility.
- B. An Out-of-Network Provider or facility providing Emergency Services, and other services as described in the requirements of the No Surprises Act.
- C. The services described in A. (2) above are not unauthorized provider services if the Insured Person gives advance written consent to the provider acknowledging that the use of a provider, or services to be rendered, may result in costs not covered under this Certificate.

If the Insured Person receives unauthorized provider services as noted above, the Insured Person's financial responsibility for the unauthorized provider services will be the same cost sharing requirements, including Copayments, Deductibles, Coinsurance, coverage restrictions, and coverage limitations, as those applicable to services received by the Insured Person from an In-Network Provider and shall be applied to the Insured Person's In-Network Provider Out-of-Pocket Maximum.

Unrestricted Access To Services For The Diagnosis, Monitoring, And Treatment Of Rare Diseases

We will not restrict the Insured Person's choice as to where they receive services from a licensed health care provider related to the diagnosis, monitoring and Treatment of a Rare Disease or condition, including, but not limited to, additional restrictions through any prior authorization, prior approval, Pre-Certification Process, increased fees, or other methods. We will provide the Insured Person with written information on this provision.

We will not deny coverage for a service solely on the basis that it was provided by, referred for, or ordered by an Out-of-Network Provider. Any prior authorization requirements for a service that is provided by, referred for, or ordered by an Out-of-Network Provider will be the same as any prior authorization requirements for those by an In-Network Provider.

Note that even if the diagnosis does not meet the definition of Rare Disease or condition, upon receipt of notice from the Insured Person, the Insured Person's cost sharing and benefit or services limitations for the diagnosis and Treatment of the disease or condition will be treated at the In-Network benefit level for up to 60 days.

For the purposes of this provision:

Rare Disease or Condition means any disease or condition that:

- 1) affects fewer than 200,000 persons in the United States and is chronic, serious, life altering, or life-threatening;
- 2) affects more than 200,000 persons in the United States and a drug for treatment has been designated as a drug for a rare disease or condition pursuant to United States Code, title 21, section 360bb;

3) is labeled as a rare disease or condition on the Genetic and Rare Diseases Information Center list created by the National Institutes of Health;

or

4) for which an Insured Person:

- has received two or more clinical consultations from a primary care provider or specialty provider that are specific to the presenting complaint;
- has documentation in the enrollee's medical record of a developmental delay through standardized assessment, developmental regression, failure to thrive, or progressive multisystemic involvement; and
- had laboratory or clinical testing that failed to provide a definitive diagnosis or resulted in conflicting diagnosis.

A rare disease or condition does not include an infectious disease that has widely available and known protocols for diagnosis and treatment and that is commonly treated in a primary care setting, even if it affects less than 200,000 persons in the United States.

Please note that while We will pay an out-of-state Out-of-Network Provider for services provided for a Rare Disease or condition at the In-Network benefit level, that Out-of-Network Provider could potentially balance bill the Insured Person for amounts above what We are required to pay them.

Continuity of Care

1. If the Insured Person is undergoing an active course of Treatment with an In-Network Provider, the Insured Person may request continuation of Treatment by such In-Network Provider in the event the In-Network Provider's contract has terminated with the Preferred Provider Organization. We shall notify the Insured Person of the termination of the In-Network Provider's contract at least 60 days in advance. When circumstances related to the termination render such notice impossible, We shall provide affected enrollees as much notice as is reasonably possible. The notice given must include instructions on obtaining an alternate provider and must offer Our assistance with obtaining an alternate provider and ensuring that there is no inappropriate disruption in the Insured Person's ongoing Treatment. We shall permit the Insured Person to continue to be covered, with respect to the course of Treatment with the provider, for a transitional period up to 120 days from the date of the notice to the Insured Person of the termination except that if the Insured Person is in the second trimester of pregnancy at the time of the termination and the provider is treating the Insured Person during the pregnancy. The transitional period must extend through the provision of postpartum care directly related to the pregnancy.
2. Unless terminated for cause, if We terminate the contract while the Insured Person is undergoing an active course of Treatment with an In-Network Provider, upon request and subject to the Termination Dates provision, We shall permit the Insured Person to continue to be covered, with respect to the course of Treatment with the provider:
 - A) For a transitional period of up to 120 days from the date of the notice if the Insured Person is engaged in a current course of Treatment for one or more of the following conditions:
 - a. an acute condition;
 - b. a life-threatening mental or physical illness;
 - c. pregnancy beyond the first trimester of pregnancy;
 - d. a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or
 - e. a disabling or chronic condition that is in an acute phase; or
 - B) For the rest of the Insured Person's life if a Physician, advanced practice registered nurse, or Physician assistant certifies that the Insured Person has an expected lifetime of 180 days or less.
3. If a newly Insured Person is undergoing an active course of Treatment with a Provider, upon request and subject to the Termination Dates provision, We shall permit the Insured Person to continue to be covered, with respect to the

course of Treatment with the provider:

- A) For a transitional period of up to 120 days from the date of the notice if the Insured Person is engaged in a current course of Treatment for one or more of the following conditions:
 - a. an acute condition;
 - b. a life-threatening mental or physical illness;
 - c. pregnancy;
 - d. a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or
 - e. a disabling or chronic condition that is in an acute phase; or
- B) For the rest of the Insured Person's life if a Physician, advanced practice registered nurse, or Physician assistant certifies that the Insured Person has an expected lifetime of 180 days or less.

Pre-Certification Process

In-Network - The Insured Person's In-Network Provider is responsible for obtaining any necessary Pre-Certification before the Insured Person receives the care. If the Insured Person's In-Network Provider does not obtain the required Pre-Certification the Insured Person will not be penalized. Please read below regarding review and notification.

Out-of-Network – The Insured Person or the Insured Person's Out-of-Network Provider is responsible for starting the Pre-Certification process. The Insured Person or the Insured Person's Out-of-Network Provider may submit the request 24/7 by: (1) calling Us at the phone number found on the Insured Student's ID card; (2) sending it to Our fax inbox at 413-781-1958, or (3) submitting it to the following email address: priorauth@wellfleetinsurance.com. For Inpatient services, the request must be made at least 5 working days prior to Hospital Confinement. For Outpatient services, the request must be made at least 5 working days prior to the start of the Outpatient service. In the case of an emergency, the request must take place as soon as reasonably possible.

The following Inpatient and Outpatient services or supplies require Pre-Certification:

- 1. Inpatient admissions, including length of stay, to a Hospital, Skilled Nursing Facility, a facility established primarily for the Treatment of a Substance Use Disorder, or a residential Treatment facility;
- 2. All Inpatient maternity care that exceeds the standard length of stay;
- 3. Home Health Care;
- 4. Durable Medical Equipment over \$500 per item;
- 5. Surgery;
- 6. Transplant Services;
- 7. Diagnostic testing/radiology;
- 8. Chemotherapy/radiation;
- 9. Infusions/injectables;
- 10. Infertility Treatment;
- 11. Outpatient Private Duty Nursing;
- 12. Botox Injections;
- 13. Orthognathic Surgery;
- 14. Genetic Testing, except for BRCA;
- 15. Orthotics/prosthetics;
- 16. Non-emergency air Ambulance (fixed wing) expenses.

Pre-Certification is not required for an Emergency Medical Condition, or Urgent Care, or Hospital Confinement for the initial 48/96 hours of maternity care.

Pre-Certification is not a guarantee that benefits will be paid.

When Pre-Certification is approved, the Insured Person's Physician will be notified of Our decision as follows:

1. For elective (non-emergency) admissions to a health care facility, We will notify the Physician and the health care facility by telephone and in writing of the number of Inpatient days, if any, approved;
2. For Confinement in a health care facility longer than the originally approved number of days, the treating Physician or the health care facility must contact Us before the last approved day. We will review the request for continued stay to determine Medical Necessity and notify the Physician or the health care facility of Our decision by telephone and in writing;
3. For any other covered services requiring Pre-Certification, We will contact the Provider by telephone and in writing regarding Our decision.

For newly Insured Persons with a previously approved Pre-Certification, We will accept the approved Pre-Certification with documentation from the health care provider for at least 60 days.

If Pre-Certification is not approved, notification of Our decision will be provided by telephone, by fax to a verified number, or by electronic mail to a secure electronic mailbox to the attending health care professional and Hospital or Physician's office as applicable. Written notification will also be sent if notification occurred by telephone.

The Insured Person will be notified in writing regarding Our decision.

Our agent will make this determination within 72 hours for an urgent request and 4 business days for non-urgent requests following receipt of all necessary information for review. Notice of an Adverse Benefit Determination made by Our agent will be in writing and will include:

1. The reasons for the Adverse Benefit Determination including the clinical rationale, if any.
2. Instructions on how to initiate an appeal.
3. Notice of the availability, upon the Insured Person's request or the Insured Person's Authorized Representative, of the clinical review criteria relied upon to make the Adverse Benefit Determination. This notice will specify what, if any additional necessary information must be provided to, or obtained by, Our agent in order to render a decision on any requested appeal.

If the Insured Person has any questions about their Pre-Certification status, the Insured Person should contact their Provider.

Covered Medical Expenses

We will pay for the following Covered Medical Expenses when they are incurred as the result of a Covered Injury or Covered Sickness or for Preventive Services.

Preventive Services

The following services shall be covered without regard to any Deductible, Coinsurance, or Copayment requirement that would otherwise apply when provided by an In-Network Provider:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
4. With respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
5. Outpatient/office contraceptive services are covered, provided that the services are related to the use of FDA approved contraceptives. Examples of covered contraceptive services are: office visits, consultations, examinations and services related to the use of federal legend oral contraception or IUD insertion, diaphragm fitting, vasectomy or contraceptive injections. Please note that prescription and nonprescription contraceptive drugs and devices

(such as oral contraceptives, IUDs, diaphragms, and contraceptive injections) are covered under the Prescription Drug Benefit. See Prescription Drugs for information on those services and devices.

6. Prenatal care services.

As used in item “6”:

Prenatal care services means the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists

7. All preexposure prophylaxis when used for the prevention or Treatment of human immunodeficiency virus, including but not limited to all preexposure prophylaxis, as defined in any guidance by the United States Preventive Services Task Force or the Centers for Disease Control, including the June 11, 2019, Preexposure Prophylaxis for the Prevention of HIV Infection United States Preventive Services Task Force Recommendation Statement; and

8. All postexposure prophylaxis when used for the prevention or Treatment of human immunodeficiency virus, including but not limited to all postexposure prophylaxis as defined in any guidance by the United States Preventive Services Task Force or the Centers for Disease Control.

9. Child health supervision services.

As used in item “9”:

Child health supervision services means pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations from ages six to 18, as defined by Standards of Child Health Care issued by the American Academy of Pediatrics. Reimbursement must be made for at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, once a year from 24 months to 72 months. Limited to one visit payable to one provider for all of the services provided at each visit.

More information about preventive services for children can be found at the following links:

- Preventive services for children age 0 to 11 months
- Preventive services for children age 1 to 4 years
- Preventive services for children age 5 to 10 years
- Preventive services for children age 11 to 14 years
- Preventive services for children age 15 to 17 years

A current list of Preventive Services can be found at: [Preventive health services | HealthCare.gov](#).

NOTE: If the covered Preventive Service is provided during a Physician’s Office Visit and it is billed separately from the office visit, You may be responsible for any Deductible, Coinsurance and/or Copayment applicable to the Physician’s Office Visit only. If the Physician’s Office Visit and the covered Preventive Service are billed together and the primary purpose of the visit was not the Preventive Service, You may be responsible for any Deductible, Coinsurance and/or Copayment applicable to the Physician’s Office Visit, including the covered Preventive Service.

Preventive Services recommendations and guidelines can be found on the [HealthCare.gov](#) website at the following links:

- For all adults: <https://www.healthcare.gov/preventive-care-adults/>
- For woman: <https://www.healthcare.gov/preventive-care-women/>
- For children: <https://www.healthcare.gov/preventive-care-children/>

Important Notes:

1. These Preventive Services recommendations and guidelines may be updated periodically. When these are updated, they will be applied to this plan. The updates will be effective on the first day of the calendar year, one year after the updated recommendation or guideline is issued.

2. Diagnostic testing for the Treatment or diagnosis of a Covered Injury or Covered Sickness will not be covered under the Preventive Services. For those types of tests and Treatment, the Insured Person will pay the cost sharing specific to Covered Medical Expense for diagnostic testing and Treatment.
3. This plan will not limit gender-specific Preventive Services based on the Insured Person's gender at birth, the Insured Person's identity, or according to other records.

To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, the Insured Person should contact their Physician or contact Us by calling the number on the Insured Student's ID card. This information can also be found at the <https://www.healthcare.gov/> website.

We may use reasonable medical management techniques to determine the frequency, method, Treatment, or setting of Preventive Services benefits when not specified in the recommendations and guidelines of the:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP)
- United States Preventive Services Task Force (USPSTF)
- Health Resources and Services Administration (HRSA)
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

Inpatient Services

1. Hospital Care - Covered Medical Expenses include the following:

- Room and Board Expenses, including general nursing care. Benefits may not exceed the daily semi-private room rate unless intensive care unit is required.
- Intensive Care Unit, including 24-hour nursing care.
- Hospital Miscellaneous Expenses, while Hospital Confined or as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as:
 - a. The cost for use of an operating room;
 - b. Prescribed medicines (excluding take-home drugs);
 - c. Laboratory tests;
 - d. Therapeutic services;
 - e. X-ray examinations;
 - f. Casts and temporary surgical appliances;
 - g. Oxygen, oxygen tent; and
 - h. Blood and blood plasma.
- Coverage for an emotionally disabled Dependent child, for their Treatment in a residential treatment facility licensed by the commissioner of human services. Residential treatment facility means a 24-hour-a-day program that provides Treatment for children with emotional disturbance and includes a licensed residential program specializing in caring 24 hours a day for children with a developmental delay or related condition. A residential treatment facility does not include a psychiatric residential treatment facility or a family foster home.

Length of stay is based on the child's residential treatment need and shall be reviewed every 90 days. Services must be appropriate to the child's age and treatment needs. Residential treatment must be designed to:

- a. help the child improve family living and social interaction skills;
- b. help the child gain the necessary skills to return to the community;
- c. stabilize crisis admissions; and
- d. work with families throughout the placement to improve the ability of the families to care for children with severe emotional disturbance in the home.

2. Preadmission Testing for routine tests performed as a preliminary to the Insured Person being admitted to a Hospital. These tests must be performed within 5 working days prior to admission. This benefit is limited to

routine tests such as complete blood count, urinalysis, and chest x-rays. Unless otherwise payable under this Certificate, We will pay for major diagnostic procedures under the Hospital Miscellaneous Expenses benefit. This includes tests such as CAT scans, cardiac catheterization, MRI's, NMR's, and blood chemistries.

3. **Physician's Visits while Confined.** Physician's visits will be paid for either inpatient or outpatient visits when incurred on the same day, but not both. Surgeon's fees are not payable under this benefit.
4. **Skilled Nursing Facility Benefit** for services received in a licensed Skilled Nursing Facility. Services must be Medically Necessary. Confinement for Custodial Care or residential care is not covered.
5. **Inpatient Rehabilitation Facility Expense Benefit** for the services, supplies and Treatments rendered to the Insured Person in an Inpatient Rehabilitation Facility. The Insured Person must enter an Inpatient Rehabilitation Facility:
 - a. After being discharged from a Hospital Confinement for a Covered Sickness or Coverage Injury; and
 - b. The services, supplies and Treatments rendered at the Inpatient Rehabilitation Facility must be related to the same Covered Sickness or Covered Injury.

Services, supplies and Treatments by an Inpatient Rehabilitation Facility include:

- a. Charges for room, board, and general nursing services;
 - b. Charges for physical, occupational, or speech therapy;
 - c. Charges for drugs, biologicals, supplies, appliances, and equipment for use in such facility, which are ordinarily furnished by the Inpatient Rehabilitation Facility for the care and Treatment of a Confined person; and
 - d. Charges for medical services of interns, in training, under a teaching program of a Hospital with which the facility has an agreement for such services
6. **Physical Therapy while Confined** when prescribed by the attending Physician.

Mental Health Disorder and Substance Use Disorder Benefits

1. **Inpatient and Outpatient Mental Health Disorder Benefit** for Treatment of Mental Health Disorders as specified on the Schedule of Benefits.

We also provide coverage for mental health Treatment ordered by a Minnesota court under a valid court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. We must be given a copy of the court order and the behavioral care evaluation, and the service must be a Covered Medical Expense under this Certificate, and the service must be provided by an In-Network Provider, or other provider as required by law.

Treatment ordered by a Minnesota court that meets the requirements of this section shall not be subject to a separate Medical Necessity determination under Our utilization review procedures.

See Treatment of Covered Injury and Covered Sickness Benefit.

2. **Inpatient and Outpatient Substance Use Disorder Benefit** for Treatment of Substance Use Disorders as specified on the Schedule of Benefits.

Coverage includes chemical dependency Treatment provided to an Insured Person by the Department of Corrections while the Insured Person is committed to the custody of the commissioner of corrections following a conviction for first degree driving while impaired offense if:

- a. A court of competent jurisdiction makes a preliminary determination based a chemical use assessment that

- Treatment may be appropriate and includes this determination as part of the sentencing order; and
- b. the Department of Corrections makes a determination based on a chemical assessment conducted while the individual is in the custody of the department that Treatment is appropriate. Treatment provided by the Department of Corrections that meets the requirements of this section shall not be subject to a separate Medical Necessity determination under Our utilization review procedures.

We must receive a copy of the court's preliminary determination and supporting documents and the assessment by the Department of Corrections.

Payment rates for Treatment provided by the Department of Corrections shall not exceed the lowest rate for outpatient chemical dependency Treatment paid by Us to an In-Network Provider.

Chemical dependency Treatment means all covered services that are intended to treat chemical dependency and that are covered under this Certificate or by law.

Coverage also includes screenings and urinalysis testing for opioids when ordered by a health care provider and performed by an accredited clinical laboratory. We will provide coverage for an Insured Person in an inpatient or outpatient Substance Use Disorder Treatment program. We may conduct a Medical Necessity review when screenings or urinalysis testing exceeds 24 tests in any 12-month period.

See Treatment of Covered Injury and Covered Sickness Benefit.

Professional and Outpatient Services

SURGICAL EXPENSES

1. **Inpatient and Outpatient Surgery including Surgeon, Anesthetist, and Assistant Surgeon Services** (including pre- and post-operative visits) as specified in the Schedule of Benefits. Covered surgical expenses will be paid under either the Inpatient Surgery benefit or the Outpatient Surgery benefit. They will not be paid under both. This benefit is not payable in addition to Physician's Visits.

Sometimes 2 or more surgical procedures can be performed during the same operation.

- a. **Through the Same Incision.** If covered multiple surgical procedures are performed through the same incision, We will pay for the procedure with the highest allowed amount and 50% of the amount We would otherwise pay under this Certificate for the secondary procedures, except for secondary procedures that, according to nationally-recognized coding rules, are exempt from multiple surgical procedure reductions. We will not pay anything for a secondary procedure that is billed with a primary procedure when that secondary procedure is incidental to the primary procedure.
 - b. **Through Different Incisions.** If covered multiple surgical procedures are performed during the same operative session but through different incisions, We will pay:
 - For the procedure with the highest allowed amount; and
 - 50% of the amount We would otherwise pay for the other procedures.
2. **Outpatient Surgical Facility and Miscellaneous** expenses benefit. Benefits will be paid for services and supplies, including:
 - a. Operating room;
 - b. Therapeutic services;
 - c. Oxygen, oxygen tent; and
 - d. Blood and blood plasma.

3. **Organ Transplant Surgery**

Recipient Surgery for Medically Necessary, non-Experimental and non-Investigative solid organ, bone marrow, stem-cell or tissue transplants. We will provide benefits for the Hospital and other Covered Medical Expenses when the Insured Person is the recipient of an Organ Transplant.

Donor's Surgery for Medically Necessary transplant services required by the Insured Person who serves as an organ donor only if the recipient is also an Insured Person. We will not cover the transplant services of a non-Insured Person acting as a donor for an Insured Person if the non-Insured Person's expenses will be covered under another health plan or program.

Travel Expenses when the facility performing the Medically Necessary transplant is located more than 200 miles from the Insured Person's residence, coverage will be provided for lodging, meals and transportation expenses (coach class only) subject to the maximum benefits shown on the Schedule of Benefits.

Non-Covered Services for transportation and lodging include, but are not limited to:

- a. Child care;
- b. Mileage within the medical transplant facility city;
- c. Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us;
- d. Frequent Flyer miles;
- e. Coupons, Vouchers, or Travel tickets;
- f. Prepayments or deposits;
- g. Services for a condition that is not directly related or a direct result of the transplant;
- h. Telephone calls;
- i. Laundry;
- j. Postage;
- k. Entertainment;
- l. Interim visits to a medical care facility while waiting for the actual transplant procedure;
- m. Travel expenses for donor companion/caregiver;
- n. Return visits for the donor for a Treatment of condition found during the evaluation.

4. **Reconstructive Surgery** covers all stages of reconstruction of the breast on which a mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and Treatment of physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and Insured Person. This benefit also covers cosmetic surgery specifically and solely for: Reconstruction when such service is incidental to or follows surgery resulting from Injury, Sickness or other disease of the involved part; or when such service is performed by the attending Physician on a covered Dependent child because of congenital disease or anomaly which has resulted in a functional defect.

OTHER PROFESSIONAL SERVICES

1. **Gender Affirming Treatment Benefit** for Medically Necessary expenses incurred for services and supplies provided in connection with gender affirming Treatment when the Insured Person has been diagnosed with gender identity disorder or gender dysphoria. Covered Medical Expenses include the following:
 - a. Counseling by qualified mental health professional;
 - b. Hormone therapy, including monitoring of such therapy;
 - c. Gender affirming surgery and procedures.
2. **Home Health Care Expenses** for the Insured Person's Home Health Care when, otherwise, hospitalization or Confinement in a Skilled Nursing Facility would have been necessary.

3. **Hospice Care Coverage** when, as the result of a Covered Injury or Covered Sickness, the Insured Person requires Hospice Care, We will pay the Covered Medical Expenses incurred for such care. The Insured Person must have been diagnosed with a terminal illness by a licensed Physician. The Insured Person must have elected to receive palliative rather than curative care. Any required documentation will be no greater than that required for the same services under Medicare.

OFFICE VISITS

1. **Physician's Office Visits.** Physician's Visits include second surgical opinions, specialists, and consultant services. Benefits will be paid for either outpatient or inpatient visits on the same day, but not both. Surgeon fees are NOT payable under this benefit.

A Physician Assistant (PA) is authorized to:

1. diagnose, prescribe, and institute therapy or referral of Insured Persons to health care agencies and providers;
2. prescribe, procure, sign for, record, administer, and dispense over-the-counter drugs, legend drugs, and controlled substances, including sample drugs; and
3. plan and initiate a therapeutic regimen that includes ordering and prescribing Durable Medical Equipment, nutrition, diagnostic services, and supportive services including but not limited to Home Health Care, Hospice, Physical Therapy, and occupational therapy.

Medically Necessary foot care is a Covered Medical Expense when systemic conditions such as metabolic, neurologic, or peripheral vascular disease exists and results in medically significant circulatory deficits or decreased sensation to the foot.

2. **Telehealth Services** for health care delivery, diagnosis, consultation, or Treatment provided to the Insured Person by a Physician or a contracted provider subject to the plan cost share shown on the Schedule of Benefits. Coverage includes Telemonitoring services when:
 - a. Medically appropriate based on the Insured Person's medical condition or status;
 - b. The Insured Person is cognitively and physically capable of operating the monitoring device or equipment, or the Insured Person has a caregiver who is willing and able to assist with the monitoring device or equipment; and
 - c. The Insured Person resides in a setting that is suitable for Telemonitoring and not in a setting that has health care staff on site.
3. **Allergy Testing and Treatment, including injections.** This includes tests that the Insured Person needs such as PRIST, RAST, and scratch tests. Also, includes Treatment of anaphylaxis and angioedema, severe chronic sinusitis not responsive to medications and asthma not responding to usual Treatments. This also includes the administration of allergy therapy, injections, allergy serum, and supplies used for allergy therapy.
4. **Chiropractic Care Benefit** for Treatment of a Covered Injury or Covered Sickness and performed by a Physician.
5. **Tuberculosis (TB) screening, Titers, QuantiFERON B tests including shots** (other than covered under Preventive Services) when required by the School for high risk Insured Persons.

Emergency Services, Ambulance and Non-Emergency Services

1. **Emergency Services** only in connection with care for an Emergency Medical Condition as defined. Benefits will be paid for the use of a Hospital emergency department or independent freestanding emergency department, a medical screening examination that is within the capability of the emergency department, including ancillary services routinely available to the emergency department, pre-stabilization services and supplies after the Insured Person is moved out of the emergency department and admitted to a Hospital, as well as any additional

services rendered after the Insured Person is Stabilized as part of Observation Services or an inpatient or outpatient stay with respect to the visit in which the other Emergency Services are furnished. Refer to the Emergency Ambulance Service provision for transportation coverage.

If the Insured Person receives Emergency Services from an Out-of-Network Provider or facility, the most the Out-of-Network Provider or facility may bill the Insured Person is the In-Network cost sharing amount. Cost sharing requirements that apply to Emergency Services received from an Out-of-Network Provider will be the same as the cost sharing requirements that apply to services received from an In-Network Provider and shall count toward the In-Network Deductible (if applicable). All coverage and charges for Emergency Services will comply with the No Surprises Act.

The Post-Stabilization services will no longer qualify as Emergency Services once the Out-of-Network Provider or facility determines that the Insured Person can travel using non-medical or non-emergency transportation, the Out-of-Network Provider satisfies the consent and notice requirements, and the Insured Person is in a condition to receive notice of, and to consent to, Out-of-Network Treatment.

In reviewing a denial of coverage of Emergency Services, the presenting symptoms, including, but not limited to, severe pain, to ensure that the decision to reimburse the Emergency Services is not made solely on the basis of the actual diagnosis will be taken into consideration. Payment of this benefit will not be denied based on the final diagnosis following Stabilization or Post-Stabilization services.

In case of a medical emergency:

When the Insured Person experiences an Emergency Medical Condition, they should go to the nearest emergency room. The Insured Person can also dial 911 or their local emergency response service for medical and Ambulance assistance. If possible, the Insured Person should call their Physician but only if a delay will not harm their health.

The Insured Person has the right to available and accessible Emergency Services 24 hours a day and 7 days a week.

2. **Urgent Care Centers (non-life-threatening conditions)** for services provided at an Urgent Care Center, as shown in the Schedule of Benefits. In the case of a life-threatening condition, the Insured Person should go to the nearest emergency room.
3. **Emergency Ambulance Service**, with respect to an Emergency Medical Condition, for ground transportation to a Hospital by a licensed Ambulance. Transportation from a facility to the Insured Person's home is not covered.

The Insured Person's plan also covers transportation to a Hospital by professional air Ambulance or water Ambulance when:

- Professional ground Ambulance transportation is not available;
- The Insured Person's condition is unstable, and requires medical supervision and rapid transport;
- The Insured Person is travelling from one Hospital to another; and
- The first Hospital cannot provide the Emergency Services the Insured Person needs; and
- The two (2) conditions above are met.

4. **Non-Emergency Ambulance Expenses** for Medically Necessary transportation by a licensed Ambulance, whether by ground or air Ambulance (fixed wing) (as appropriate), when the transportation is:
 - From an Out-of-Network Hospital to an In-Network Hospital;
 - To a Hospital that provides a higher level of care that was not available at the original Hospital;
 - To a more cost-effective acute care Hospital/facility; or

- From an acute care Hospital/facility to a sub-acute setting.

Transportation from a facility to the Insured Person's home is not covered.

Diagnostic Laboratory, Testing and Imaging Services

1. **Diagnostic Imaging Services** for diagnostic X-ray services when prescribed by a Physician.
2. **CT Scan, MRI and/or PET Scans** for diagnostic services when prescribed by a Physician.
3. **Laboratory Procedures (Outpatient)** for laboratory procedures when prescribed by a Physician.
4. **Chemotherapy and Radiation Therapy** for chemotherapy, oral chemotherapy drugs, and radiation therapy to treat or control a serious illness.
5. **Infusion Therapy** for the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Rehabilitation and Habilitation Therapies

1. **Cardiac Rehabilitation.** Benefits are available for Outpatient cardiac Rehabilitation programs. Covered Medical Expenses are: exercise and education under the direct supervision of skilled program personnel in the intensive Rehabilitation phase of the program.

No benefits are available for portions of a cardiac Rehabilitation program extending beyond the intensive Rehabilitation phase. On-going or life-long exercise and education maintenance programs intended to maintain fitness or to reinforce permanent lifestyle changes are not covered.

2. **Pulmonary Rehabilitation.** Benefits are available for pulmonary Rehabilitation services as part of an inpatient Hospital stay if it is part of a treatment plan ordered by a Physician. A course of outpatient pulmonary Rehabilitation may also be eligible for coverage if it is performed at a Hospital, Skilled Nursing Facility, or Physician's office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by a Physician.
3. **Rehabilitation Therapy** when prescribed by the attending Physician, limited to 1 visit per day.
4. **Habilitation Services** when prescribed by the attending Physician, limited to 1 visit per day.

Other Services and Supplies

1. **Covered Clinical Trials** includes coverage for routine costs associated with the Insured Person's participation in a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection, or Treatment of cancer or other life-threatening disease or condition and is not designed exclusively to test toxicity or disease pathophysiology and must be:
 - a. conducted under an investigational new drug application reviewed by the United States Food and Drug Administration (FDA);
 - b. exempt from obtaining an investigational new drug application; or
 - c. approved or funded by:
 - i. the National Institutes of Health (NIH), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services, or a cooperating

- group or center of any of the entities described in this item;
- ii. a cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs;
- iii. a qualified nongovernmental research entity identified in the guidelines issued by the NIH for center support grants; or
- iv. the United States Departments of Veterans Affairs, Defense, or Energy if the trial has been reviewed or approved through a system of peer review determined by the secretary to:
 - (A) be comparable to the system of peer review of studies and investigations used by the NIH; and
 - (B) provide an unbiased scientific review by qualified individuals who have no interest in the outcome of the review.

Qualified individual means an individual with health plan coverage who is eligible to participate in an approved clinical trial according to the trial protocol for the Treatment of cancer or a life-threatening condition because:

- a. the referring health care professional is participating in the trial and has concluded that the individual's participation in the trial would be appropriate; or
- b. the individual provides medical and scientific information establishing that the individual's participation in the trial is appropriate because the individual meets the conditions described in the trial protocol.

Routine patient costs does not include:

- a. an investigational item, device, or service that is part of the trial;
- b. an item or service provided solely to satisfy data collection and analysis needs for the trial if the item or service is not used in the direct clinical management of the patient;
- c. a service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis; or
- d. an item or service customarily provided and paid for by the sponsor of a trial.

We cover routine patient costs for services that would be eligible under this Certificate if the service were provided outside of a clinical trial. Coverage does not include the studied device, equipment or drug, data collection services and any service not associated with direct clinical care to the Insured Person.

2. **Diabetic Services and Supplies (including equipment and training)** includes coverage for the cost associated with equipment, supplies, and self-management training and education for the Treatment of all types of diabetes mellitus when prescribed by a Physician.

Benefits include, but are not limited to, the following services and supplies:

- Insulin preparations
- Foot care to minimize the risk of infection
- Injection aids for the blind
- Diabetic test agents
- Prescribed oral medications whose primary purpose is to control blood sugar
- Injectable glucagon
- Glucagon emergency kits

Equipment

- External insulin pumps
- Blood glucose monitors without special features, unless required for the legally blind
- Podiatric appliances for the prevention of complications associated with diabetes

Training

- Self-management training
- Patient management materials that provide essential diabetes self-management information

“Self-management training” is a day care program of educational services and self-care designed to instruct the Insured Person in the self-management of diabetes, including medical nutritional therapy that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. The training must be provided by an American Diabetes Association Recognized Diabetes Self-Management Education Program or Physician whose scope of practice includes diabetic education or management.

This coverage includes the Treatment of insulin (type I) and non-insulin dependent (type II) diabetes and the Treatment of elevated blood glucose levels during pregnancy.

Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.

3. **Dialysis Treatment** of an acute or chronic kidney ailment, provided in an Outpatient facility of a Hospital, a free-standing renal Dialysis facility or in the Insured Person’s home. Covered Medical Expenses for home Treatment will include equipment, training and medical supplies. Private Duty Nursing is not covered.
4. **Durable Medical Equipment** for the rental or purchase of Durable Medical Equipment, including, but not limited to, Hospital beds, wheelchairs, walkers, braces that stabilize an injured body part and braces to treat curvature of the spine. We will pay the lesser of either the rental or purchase charges, but not both. Such equipment must be prescribed by a Physician and a copy of the written prescription must accompany the claim. Durable Medical Equipment must:
 - a. Be primarily and customarily used to serve a medical, rehabilitative purpose;
 - b. Be able to withstand repeated use; and
 - c. Generally, not be useful to a person in the absence of Injury or Sickness.

For more information on Durable Medical equipment, please call Us at 877-657-5030 or send a written request to:

Wellfleet Insurance Company
Attention: Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369
Web address: www.wellfleetstudent.com

5. **Enteral Formulas and Nutritional Supplements** Covered Medical Expenses prescribed by a Physician used to treat malabsorption of food caused by:
 - Crohn’s Disease
 - Ulcerative colitis
 - Gastroesophageal reflux
 - Gastrointestinal motility;
 - Chronic intestinal pseudo-obstruction
 - Phenylketonuria
 - Eosinophilic gastrointestinal disorders
 - Inherited diseases of amino acids and organic acids
 - Multiple severe food allergies
 - Branched-chain ketonuria,
 - Galactosemia
 - Homocystinuria

Covered benefits also include food products modified to be low in protein for inherited diseases of amino acids and organic acids. For purposes of this benefit, “low protein modified food product” means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the

direction of a Physician for the dietary Treatment of any inherited metabolic illness. Low protein modified food products do not include foods that are naturally low in protein.

6. **Hearing Aids** for Insured Persons when prescribed by a Physician. Coverage is for Medically Necessary hearing aids for Insured Persons who have hearing loss that is not correctable by other covered procedures. Benefits are limited as shown in the Schedule of Benefits.
7. **Infertility Treatment** We cover services for the Treatment (surgical and medical) of infertility when such infertility is the result of malformation, disease or dysfunction or a correctable medical condition otherwise covered under the plan. Such coverage is available as follows:
 1. **Basic Infertility Services.** Basic infertility services will be provided to an Insured Person who is an appropriate candidate for infertility Treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, and the American Society for Reproductive Medicine.

Basic infertility services include:

- Initial evaluation;
- Semen analysis;
- Laboratory evaluation;
- Evaluation of ovulatory function;
- Postcoital test;
- Endometrial biopsy;
- Pelvic ultra sound;
- Hysterosalpingogram;
- Sonohysterogram;
- Testis biopsy;
- Blood tests; and
- Medically appropriate Treatment of ovulatory dysfunction.

Additional tests may be covered if the tests are determined to be Medically Necessary.

All services must be provided by Physicians who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.

8. **Maternity Benefit** for maternity charges as follows:
 - a. **Routine prenatal care**
 - b. **Hospital stays** for mother and newly born child will be provided for up to 48 hours for normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery unless the caesarean section delivery is the result of Complications of Pregnancy. If the delivery is the result of Complications of Pregnancy, We will cover any additional days of such care that We determine are Medically Necessary. Services of a licensed Nurse midwife are covered when rendered in a Hospital or licensed outpatient facility rendering maternity services.

Home Births are also covered when services are rendered by a certified registered Nurse midwife.

Services covered as inpatient care will include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.

- c. **Inpatient Physician charges or Surgeon charges** will be covered the same as for any other Covered Sickness for both mother and newborn child.

d. **Physician-directed Follow-up Care** including:

1. Physician assessment of the mother and newborn;
2. Parent education;
3. Assistance and training in breast or bottle feeding;
4. Assessment of the home support system;
5. Performance of any prescribed clinical tests; and
6. Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric obstetrical and nursing professionals.

This benefit will apply to services provided in a medical setting or through Home Health Care visits. We will provide coverage for postdelivery care to mother and newly born child if the duration of inpatient care is less than the minimums shown in item “b”. Any Home Health Care visit must be provided by an individual knowledgeable and experienced in maternity and newborn care. All Home Health Care visits that are made necessary by early discharge from the Hospital must be performed within 4 days after discharge. When a mother or a newborn receives at least the number of hours of inpatient care shown in item “b”, the Home Health Care visit benefit will apply to follow-up care that is determined to be necessary by the health care professionals responsible for discharging the mother or newborn. Postdelivery care consists of a minimum of one home visit by a registered nurse. Services provided by the registered nurse include, but are not limited to:

1. Parent education;
2. Assistance and training in breast or bottle feeding; and
3. Conducting any necessary and appropriate clinical tests.

e. **Outpatient Physician’s visits** will be covered the same as for any other Covered Sickness.

f. **Comprehensive postnatal care visits** with a health care provider will be covered the same as for any other Covered Sickness. Coverage includes a full assessment of the mother's and newly born child's physical, social, and psychological well-being, including but not limited to:

- mood and emotional well-being;
- infant care and feeding;
- sexuality, contraception, and birth spacing;
- sleep and fatigue;
- physical recovery from birth;
- chronic disease management; and
- health maintenance.

Coverage includes:

1. a comprehensive postnatal visit with a health care provider not more than 3 weeks from the date of delivery;
2. any postnatal visits recommended by a health care provider between 3 and 11 weeks from the date of delivery; and
3. a comprehensive postnatal visit with a health care provider 12 weeks from the date of delivery.

Coverage for comprehensive postnatal care visits is in addition to the postdelivery visits shown in item “d”.

9. **Prosthetic and Orthotic Devices** to replace all or part of a body organ, or replace all or part of the function of a permanently inoperative, absent, or malfunctioning body part when Medically Necessary and prescribed by a Physician. Prosthetics also includes scalp hair prosthesis for an Insured Person for hair loss suffered as a result of alopecia areata, limited to 1 prosthesis per Policy year.

10. **Outpatient Private Duty Nursing** services for non-hospitalized care performed by a R.N. or L.P.N for a Covered Injury or Covered Sickness if the condition requires skilled nursing care and visiting nursing care is not adequate. Services must be:
- Rendered in the home;
 - Prescribed by the attending Physician as being Medically Necessary; and
 - Performed by a certified Home Health Care Agency.

If coverage for services is provided by a private duty nurse or personal care assistant to a ventilator-dependent Insured Person in the Insured Person's home, coverage will also include up to 120 hours of services provided by a private duty nurse or personal assistant to the ventilator-dependent Insured Person during the time the ventilator-dependent Insured Person is in a Hospital. The private duty nurse or personal care assistant shall perform only the services of communicator or interpreter for the ventilator-dependent Insured Person during a transition period of up to 120 hours to assure adequate training of the Hospital staff to communicate with the Insured Person and to understand the unique comfort, safety, and personal care needs of the Insured Person.

11. **Student Health Center/Infirmary Expense Benefit** if an Insured Person incurs Covered Medical Expenses as the result of Treatment at a Student Health Center/Infirmary, We will pay the Covered Medical Expenses incurred. Benefits will not exceed the amount shown in the Schedule of Benefits.
12. **Sports Accident Expense Benefit** for an Insured Student as the result of covered sports Accident while at play or practice of intercollegiate or club sports as shown in the Schedule of Benefits.
13. **Non-emergency Care While Traveling Outside of the United States** for Medically Necessary Treatment when the Insured Person is traveling outside of the United States.
14. **Medical Evacuation Expense**
The maximum benefit for Medical Evacuation, if any, is shown in the Schedule of Benefits.

If the Insured Student is unable to continue their academic program as the result of a Covered Injury or Covered Sickness that occurs while the Insured Person is covered under this Certificate, We will pay the necessary Actual Charges for evacuation to another medical facility or the Insured Person's Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

Payment of this benefit is subject to the following conditions:

- a. The Insured Person must have been in a Hospital due to a Covered Injury or Covered Sickness for a Confinement of 5 or more consecutive days immediately prior to medical evacuation;
- b. Prior to the medical evacuation occurring, the attending Physician must have recommended, and We must have approved, the medical evacuation;
- c. We must approve the expenses incurred prior to the medical evacuation occurring, if applicable;
- d. No benefits are payable for expenses after the date the Insured Person's insurance terminates. However, if on the date of termination, the Insured Person is in the Hospital, this benefit continues in force until the earlier of the date the Confinement ends or 31 days after the date of termination;
- e. Evacuation to the Insured Person's Home Country terminates any further insurance coverage under this Certificate for the Insured Person; and
- f. Transportation must be by the most direct and economical route.

15. **Repatriation Expense**
The maximum benefit for Repatriation, if any, is shown in the Schedule of Benefits.

If the Insured Person dies while they are traveling 100 or more miles from their place of residence and/or outside their Home Country, We will pay a benefit. The benefit will be the necessary charges for preparation, including cremation, and transportation of the remains to the Insured Person's place of residence or Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

Pediatric and Adult Dental and Vision Benefits

1. **Pediatric Dental Care Benefit** for the following dental care services for Insured Persons (to the end of the month in which the Insured Person turns age 19):
 - a. Preventive Dental Care, that includes procedures which help to prevent oral disease from occurring, including:
 1. Dental examinations, visits and consultations once within a 6-month consecutive period (when primary teeth erupt);
 2. X-ray, full mouth x-rays at 36-month intervals, bitewing x-rays at 6 to 12-month intervals, or panoramic x-rays at 36-month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
 3. Prophylaxis (scaling and polishing the teeth) at 6-month intervals;
 4. Topical fluoride application at 6-month intervals where the local water supply is not fluoridated;
 5. Sealants on unrestored permanent molar teeth; and
 6. Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.
 - b. Emergency Dental care, which includes emergency palliative Treatment required to alleviate pain and suffering caused by dental disease or trauma.
 - c. Routine Dental Care: We cover routine dental care provided in the office of a Dental Provider, including:
 1. Procedures for simple extractions and other routine dental surgery not requiring hospitalization, including preoperative care and postoperative care;
 2. In-office conscious sedation;
 3. Amalgam, composite restorations and stainless-steel crowns; and
 4. Other restorative materials appropriate for children.
 - d. Endodontic Services, including procedures for Treatment of diseased pulp chambers and pulp canals, where hospitalization is not required.
 - e. Prosthodontic Services as follows:
 1. Removable complete or partial dentures, including 6-months follow-up care; and
 2. Additional services include insertion of identification slips, repairs, relines and rebases and Treatment of cleft palate.

Fixed bridges are not covered unless they are required:

 1. For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth;
 2. For cleft palate stabilization; or
 3. Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.
 - f. Periodontic Services include but are not limited to:
 1. root planning and scaling at 24-month intervals;
 2. gingivectomy at 36-month intervals;
 3. gingival flap procedures at 36-month intervals; and
 4. osseous surgery (including flap and closure) at 5 year intervals.

- g. Medically Necessary Orthodontic Care to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasia's.

Procedures include but are not limited to:

- 1. Rapid Palatal Expansion (RPE);
- 2. Placement of component parts (e.g. brackets, bands);
- 3. Interceptive orthodontic Treatment;
- 4. Comprehensive orthodontic Treatment (during which orthodontic appliances are placed for active Treatment and periodically adjusted);
- 5. Removable appliance therapy; and
- 6. Orthodontic retention (removal of appliances, construction and placement of retainers).

- 2. **Adult Dental Care Benefit** for the following dental care services for Insured Persons age 19 and older:
 - a. Preventive Dental Care, that includes procedures which help to prevent oral disease from occurring, including:
 - 1. Dental examinations, visits and consultations as specified in the Schedule of Benefits;
 - 2. X-ray, full mouth x-rays at 36 month intervals, bitewing x-rays at 6 to 12 month intervals, or panoramic x-rays at 36 month intervals;
 - 3. Prophylaxis (scaling and polishing) the teeth at 6 month intervals; and
 - 4. Topical fluoride application at 6 month intervals where the local water supply is not fluoridated.
- 3. **Pediatric Vision Care Benefit** for Insured Persons (to the end of the month in which the Insured Person turns age 19).
We will provide benefits for:
 - a. 1 vision examinations per Policy Year; and
 - b. 1 pairs of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year.
- 4. **Adult Vision Care** for Insured Persons age 19 and older. We will provide benefits for a routine eye examination once every 12 months.

Miscellaneous Dental Services

- 1. **Accidental Injury Dental Treatment** as the result of Injury to Teeth. Treatment must be initiated within 6 months of the date of Covered Injury. Services must be provided within 24 months of the date of Covered Injury. Routine dental care and Treatment are not payable under this benefit. Damage to teeth due to chewing or biting is not deemed an accidental Injury and is not covered.
- 2. **Sickness Dental Expense Benefit** when, by reason of Sickness, the Insured Person requires Treatment for impacted wisdom teeth or dental abscesses, We will pay the Covered Medical Expenses incurred for the Treatment.
- 3. **Treatment for Temporomandibular Joint (TMJ) Disorders** for the surgical and non-surgical Treatment provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders. Coverage shall be the same as Treatment for any other joint in the body. Treatment must be administered or prescribed by a Physician or dentist.
- 4. **Anesthesia and Hospital Charges for Dental Care** for an Insured Person who is a child under age five; or is severely disabled; or has a medical condition, and who requires hospitalization or general anesthesia for dental care Treatment. Coverage is provided for general anesthesia and Treatment rendered by a Dental Provider for a covered condition, regardless of whether the services are provided in a Hospital or a dental office.

Prescription Drugs

1. **Prescription Drugs** are medications filled in an outpatient pharmacy for which a Physician's written prescription is required. This benefit is limited to medication necessary for the Treatment of the Covered Injury or Covered Sickness for which a claim is made. Some outpatient Prescription Drugs are subject to pre-certification. These prescription requirements help the Insured Person's prescriber and pharmacists check that the Insured Person's outpatient Prescription Drug is clinically appropriate using evidence-based criteria.

- a. **Off-Label Drug Treatments** – When Prescription Drugs are provided as a benefit under this Certificate, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:

1. The drug is prescribed for the Treatment of a life-threatening condition, including cancer, HIV or AIDS;
2. The drug has been recognized for Treatment of that condition by a nationally recognized drug database or two separate articles in major peer reviewed medical journals/clinical practice guidelines (cancer indications will only require evidence from ONE article or clinical practice guideline).

When this portion of the prescription benefit is used, it will be the responsibility of the prescriber to submit to Us documentation supporting compliance with the requirements of this benefit.

As it pertains to this benefit, life threatening means either or both of the following:

- a. Disease or conditions where the likelihood of death is high unless the course of the disease is interrupted; or
 - b. Disease or conditions with a potentially fatal outcome and where the end point of clinical intervention is survival.
- b. **Dispense as Written (DAW)** – If a prescriber prescribes a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available and specifies: "Dispense as Written" (DAW), the Insured Person will pay the cost sharing for the Brand-Name Prescription Drug. If a prescriber does not specify DAW and the Insured Person requests a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available, the Insured Person will be responsible for the cost difference between the Brand-Name Prescription Drug and the Generic Prescription Drug equivalent, and the cost sharing that applies to Brand-Name Prescription Drugs. This DAW penalty does not apply to the Insured Person's Out-of-Pocket Maximum or Deductible.
 - c. **Investigational Drugs and Medical Devices** – The Prescription Drug benefit includes a drug or device that is Investigational if the intended use of the drug or device is included in the labeling authorized by the FDA or if the use of the drug or device is recognized in one of the standard reference compendia or in peer-reviewed medical literature.
 - d. **Specialty Prescription Drugs** are limited to no more than a 30 day supply. However, if the Specialty Prescription Drug dispensed is the smallest package size available and exceeds a 30 day supply, the Insured Person is responsible for the cost sharing defined for the day supply as shown in the Schedule of Benefits.

Specialty Drugs – are Prescription Drugs which:

1. Are used in the management of chronic, orphan, or rare diseases;
2. Require specialized storage, distribution, and/or handling;
3. Have frequent dosing adjustments and clinical monitoring to decrease potential for drug toxicity and improve clinical outcomes;
4. Involve additional patient education, adherence, and/or support;
5. May include generic or biosimilar products; and/or

6. May have limited or exclusive drug distribution restrictions.

Specialty Prescription Drugs are identified in the Formulary posted on Our website.

- e. **Self-Administered Prescription Drugs** – Certain self-administered Prescription Drugs are only covered under the Prescription Drug benefit and are excluded from the medical benefits. Self-administered Prescription Drugs will not be covered when dispensed through a Physician’s office or outpatient Hospital, except in emergency situations. While Insured Persons may self-administer these medications, they can still obtain these medications at the pharmacy and have them administered at an office visit. Coverage exceptions may be granted if self-administered Prescription Drugs are required as part of a hospitalization or emergency room visit. The list of self-administered Prescription Drugs only covered under the Prescription Drug benefit and excluded from the medical benefit can be found on Our website.
- f. **Retail Pharmacy Supply Limits** – We will pay for no more than a 30 day supply of a Prescription Drug purchased at a retail pharmacy. The Insured Person is responsible for 1 cost sharing amount for up to a 30 day supply. However, if the Prescription Drug dispensed is the smallest package size available and exceeds a 30 day supply, the Insured Person is responsible for the cost sharing defined for the day supply as shown in the Schedule of Benefits.
- g. **Step Therapy** – We shall consider available recognized evidence-based and peer-reviewed clinical practice guidelines when establishing a step therapy protocol. Upon written request of the Insured Person, We shall provide any clinical review criteria applicable to a specific Prescription Drug covered by this Certificate. When medications for the Treatment of any medical condition are restricted for use by a step therapy or fail-first protocol, the prescribing practitioner shall have access to a clear, readily accessible, and convenient process to request an override of the restriction from Us. An override of that restriction will be granted by Us if at least one of the following documented circumstances exists:
 1. The Prescription Drug required under the step therapy protocol is contraindicated pursuant to the pharmaceutical manufacturer's prescribing information for the drug or, due to a documented adverse event with a previous use or a documented medical condition, including a comorbid condition, is likely to do any of the following:
 - a. cause an adverse reaction to the Insured Person;
 - b. decrease the ability of the Insured Person to achieve or maintain reasonable functional ability in performing daily activities; or
 - c. cause physical or mental harm to the Insured Person;
 2. The Insured Person has had a trial of the required Prescription Drug covered by this Certificate or previous health plan, or another Prescription Drug in the same pharmacologic class or with the same mechanism of action, and was adherent during such trial for a period of time sufficient to allow for a positive treatment outcome, and the Prescription Drug was discontinued by the Insured Person’s health care provider due to lack of effectiveness, or an adverse event. This clause does not prohibit Us from requiring the Insured Person to try another drug in the same pharmacologic class or with the same mechanism of action if that therapy sequence is supported by the evidence-based and peer-reviewed clinical practice guideline, Food and Drug Administration label, or pharmaceutical manufacturer's prescribing information; or
 3. The Insured Person is currently receiving a positive therapeutic outcome on a Prescription Drug for the medical condition under consideration if, while covered under this Certificate or the immediately preceding health plan, the Insured Person received coverage for the Prescription Drug and the Insured Person’s prescribing practitioner gives documentation to Us that the change in Prescription Drug required by the step therapy protocol is expected to be ineffective or cause harm to the Insured Person based on the known characteristics of the specific Insured Person and the known characteristics of the required prescription drug.

Upon granting a step therapy override, We shall authorize coverage for the Prescription Drug if the Prescription Drug is a covered Prescription Drug under this Certificate.

The Insured Person, or the prescribing practitioner if designated by the Insured Person, may appeal the denial of a step therapy override by Us by filing a Complaint. See the Complaints and Appeals Procedures section.

In a denial of an override request and any subsequent appeal, Our decision must specifically state why the step therapy override request did not meet at least one of the conditions listed in 1., 2., or 3. above cited by the prescribing practitioner in requesting the step therapy override and information regarding the procedure to request external review of the denial. A denial of a request for a step therapy override that is upheld on appeal is a final Adverse Benefit Determination and is eligible for a request for external review by the Insured Person.

We shall respond to a step therapy override request or an appeal within 5 days of receipt of a complete request. In cases where exigent circumstances exist, We shall respond within 72 hours of receipt of a complete request. If We do not send a response to the Insured Person, or prescribing practitioner if designated by the Insured Person, within the time allotted, the override request or appeal is granted and binding on Us.

We will not impose a step therapy protocol for a Prescription Drug approved by the FDA that is on Our Formulary if:

1. The Prescription Drug is used to treat the Insured Person's stage four advanced metastatic cancer or associated conditions; and
2. Use of the approved drug is consistent with:
 - a United States Food and Drug Administration-approved indication; and
 - a clinical practice guideline published by the National Comprehensive Care Network.

As used in this benefit:

Clinical practice guideline means a systematically developed statement to assist health care providers and Insured Persons in making decisions about appropriate health care services for specific clinical circumstances and conditions developed independently of Us, the pharmaceutical manufacturer, or any entity with a conflict of interest.

Clinical review criteria means the written screening procedures, decision abstracts, clinical protocols, and clinical practice guidelines used by Us to determine the Medical Necessity and appropriateness of health care services.

Step therapy protocol means a protocol or program that establishes the specific sequence in which Prescription Drugs for a specified medical condition, including self-administered and physician-administered drugs, are medically appropriate for a particular Insured Person and are covered under this Certificate.

Step therapy override means that the step therapy protocol is overridden in favor of coverage of the selected prescription drug of the prescribing practitioner because at least one of the conditions listed in 1., 2., or 3. above exists.

- h. **Quantity Limits** – Some Outpatient Prescription Drugs are subject to quantity limits. The quantity limits help the prescriber and pharmacist check that the Outpatient Prescription Drug is used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by Us to set these quantity limits.

- i. **Tier Status** – The tier status of a Prescription Drug may change periodically. These changes may occur without prior notice to the Insured Person. However, if the Insured Person has a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Prescription Drug that becomes available as a Generic Prescription Drug) We will notify the Insured Person. When such changes occur, the Insured Person's out-of-pocket expense may change. The Insured Person may access the most up to date tier status on Our website or by calling the number on the Insured Student's ID card.
- j. **Compounded Prescription Drugs** will be covered only when they contain at least 1 ingredient that is a covered legend Prescription Drug, do not contain bulk chemicals, and are obtained from a pharmacy that is approved for compounding. Compounded Prescription Drugs may require the Insured Person's Provider to obtain Preauthorization. Compounded Prescription Drugs will be covered as the tier associated with the highest tier ingredient.
- k. **Formulary Exception Process** – If a Prescription Drug is not on Our Formulary, the Insured Person, the Insured Person's Authorized Representative or the Insured Person's prescribing Physician may request a Formulary exception for clinically appropriate Prescription Drug in writing, electronically or telephonically. If coverage is denied under Our standard or expedited Formulary exception process, the Insured Person is entitled to an external appeal as outlined in the External Appeal section of this Certificate. Refer to the Formulary posted on Our website or call the number on the Insured Student's ID card to find out more about this process.

Standard Review of a Formulary Exception – We will make a decision and notify the Insured Person or the Insured Person's Authorized Representative and the prescribing Health Care Professional no later than 72 hours after Our receipt of the Insured Person's request. If We approve the request, We will cover the Prescription Drug while the Insured Person is taking the Prescription Drug, including any refills. This approval authorization requires renewal at least every 12 months.

Expedited Review of Formulary Exception – If the Insured Person is suffering from a health condition that may seriously jeopardize their health, life or ability to regain maximum function or if the Insured Person is undergoing a current course of Treatment using a Non-Formulary Prescription Drug, the Insured Person may request an expedited review of a Formulary exception. These requests should include a statement from the Insured Person's prescribing Physician that harm could reasonably come to the Insured Person if the requested drug is not provided within the timeframes for Our standard Formulary exception process. We will make a decision and notify the Insured Person or the Insured Person's Authorized Representative and the prescribing Physician no later than 24 hours after Our receipt of the Insured Person's request. If We approve the request, We will cover the Prescription Drug. This approval authorization requires renewal at least every 12 months. Refer to the Formulary posted on Our website or call the number on the Insured Student's ID card to find out more about this non-Formulary drug exception process

Unless removed from Our Formulary for safety reasons, antipsychotic drugs prescribed to treat emotional disturbance or mental illness will be covered regardless of whether the drug is on the Formulary, if the Physician prescribing the drug:

1. Indicates to the dispensing pharmacist, orally or in writing, that the prescription must be dispensed as communicated; and
2. Certifies in writing to Us that the Insured Person's Physician has considered all equivalent drugs in the Formulary and has determined that the drug prescribed will best treat the Insured Person's condition.

We must promptly grant an exception to the Formulary for an Insured Person when the Physician prescribing the drug indicates to Us that:

1. The Formulary drug causes an adverse reaction in the Insured Person;
2. The Formulary drug is contraindicated for the Insured Person; or
3. The Physician demonstrates to Us that the Prescription Drug must be dispensed as written to provide

maximum medical benefit to the Insured Person.

- l. **Tobacco cessation prescription and over-the-counter drugs** – Tobacco cessation Prescription Drugs and OTC drugs will be covered for two 90-day treatment regimens only. Any additional prescription drug treatment regimens will be subject to the cost sharing as shown in the Schedule of Benefits. For details on the current list of tobacco cessation Prescription Drugs and OTC drugs covered with no cost sharing during the two 90-day treatment regimens allowed, refer to the Formulary posted on Our website or call the toll-free number on the Insured Student's ID card.
- m. **Zero Cost Drugs** – In addition to ACA Preventive Care medications, certain Prescription Drugs are covered at no cost to the Insured Person. These zero cost drugs can be identified in the Formulary posted on Our website.
- n. **Preventive contraceptives** - The Insured Person's Outpatient Prescription Drug benefits cover certain Prescription drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a Physician and the prescription is submitted to the pharmacist for processing. The Insured Person's outpatient Prescription Drug benefits also cover related services and supplies needed to administer covered devices. At least 1 form of contraception in each of the methods identified by the FDA is included. The Insured Person can access the list of contraceptive prescription drugs by referring to the Formulary posted on Our website or calling the toll-free number on the Insured Student's ID card.

We will pay for up to a 12-month supply of an FDA-approved prescription contraceptive in a single dispensing.

We cover over-the-counter (OTC) and Generic Prescription Drugs and devices for each of the methods identified by the FDA at no cost share. If a Generic Prescription Drug or device is not available for a certain method, the Insured Person may obtain a certain Brand-Name Prescription Drug for that method at no cost share.

- o. **Orally administered anti-cancer drugs, including chemotherapy drugs** - Covered Medical Expenses include any drug prescribed for the Treatment of cancer if it is recognized for Treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication.
- p. **Diabetic supplies** - The following diabetic supplies may be obtained under the Insured Person's Prescription Drug benefit upon prescription by a Physician:
 - Insulin
 - Insulin syringes and needles
 - Blood glucose and urine test strips
 - Lancets
 - Alcohol swabs
 - Blood glucose monitors and continuous glucose meters

The Insured Person can identify covered diabetic supplies by referring to the Formulary posted on Our website or by calling the toll-free number on the Insured Student's ID card. Refer to the Diabetic Services and Supplies (including equipment and training) provision for diabetic services and supplies covered under the Diabetic Services and Supplies (including equipment and training) benefit.

- q. **Preventive Care drugs and Supplements**- Covered Medical Expenses include preventive care drugs and supplements (including over the counter drug and supplements as required by the Affordable Care Act (ACA)

guidelines when prescribed by a Physician and the prescription is submitted to the pharmacist for processing.

- r. **Prescription Eye Drops Coverage** –a refill of prescription eye drops will be covered if the refill is requested by the Insured Person; and if the prescribing practitioner indicated on the original prescription that additional quantities are needed and the refill requested by the Insured Person does not exceed the number of additional quantities needed.

Coverage will only be provided if the Insured Person makes a refill request for:

1. a 30-day refill supply and the request is made between 21 and 30 days from the later of:
 - (a) the original date that the prescription was distributed to the insured; or
 - (b) the date the most recent refill was distributed to the Insured Person; or
2. a 90-day refill supply and the request is made between 75 and 90 days from the later of:
 - (a) the original date that the prescription was distributed to the Insured Person; or
 - (b) the date the most recent refill was distributed to the Insured Person.

Mandated Benefits for Minnesota

Mandate Disclaimer: If any Preventive Services Benefit is subject to the mandated benefits required by state law, they will be administered under the federal or state guideline, whichever is more favorable to the Insured Person.

1. **Cleft Lip and Cleft Palate Benefits for Dependent Children** for inpatient or outpatient expenses arising from medical and dental Treatment, including orthodontic and oral surgery Treatment, involved in the management of birth defects known as cleft lip and cleft palate. Benefits for Dependent children ages 19 and over are limited to inpatient and outpatient expenses arising from medical and dental Treatment that was scheduled or initiated prior to the Dependent child turning age 19. If orthodontic services are eligible for coverage under a dental insurance plan, the dental plan shall be primary and coverage under this Certificate shall be secondary. Payment for dental or orthodontic Treatment not related to the management of the congenital condition of cleft lip and cleft palate shall not be covered under this benefit.
2. **Lyme Disease** for the Treatment of an Insured Person who is diagnosed with Lyme disease.
3. **Port-wine stain** coverage for the elimination or maximum feasible Treatment of an Insured Person's port-wine stain.
4. **Prostate Cancer Screening** for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older. The screening must consist at a minimum of a prostate-specific antigen blood test and a digital rectal examination. Benefits will be paid on the same basis as any other Preventive Service.
5. **Routine Cancer Screenings** for routine screening procedures for cancer and the office or facility visit, including mammograms, surveillance tests for ovarian cancer for women who are at risk for ovarian cancer, pap smears, and colorectal screening tests for men and women, when ordered or provided by a Physician in accordance with the standard practice of medicine.

Mammogram coverage for a preventive mammogram screening:

- a. includes digital breast tomosynthesis for enrollees at risk for breast cancer, and
- b. is covered as a Preventive Service.

Coverage includes additional diagnostic services or testing after a mammogram, if a health care provider determines they are required for the Insured Person.

At Risk for Breast Cancer means:

- a. having a family history with one or more first-or second-degree relatives with breast cancer;
- b. testing positive for BRCA1 or BRCA2 mutations;
- c. having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or
- d. having a previous diagnosis of breast cancer.

As used in this benefit:

At risk for ovarian cancer means:

- a. Having a family history:
 - i. with one or more first or second-degree relatives with ovarian cancer;
 - ii. of clusters of women relatives with breast cancer; or
 - iii. of nonpolyposis colorectal cancer; or
- b. Testing positive for BRCA1 or BRCA2 mutations.

Surveillance tests for ovarian cancer means annual screening using:

- a. CA-125 serum tumor marker testing;
- b. transvaginal ultrasound;
- c. pelvic examination; or
- d. other proven ovarian cancer screening tests currently being evaluated by the FDA or by the National Cancer Institute.

Digital breast tomosynthesis means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.

6. **PANDAS (Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections) and PANS (Pediatric Acute-Onset Neuropsychiatric Syndrome) Coverage.** We will provide coverage for Treatment for PANDAS or PANS that are recommended by the Insured Person's Physician, including but not limited to:
- Antibiotics;
 - Medication and behavioral therapies to manage neuropsychiatric symptoms;
 - Plasma exchange; and
 - Immunoglobulin

As used in this benefit:

PANDAS means a condition in which a streptococcal infection in a child or adolescent causes the abrupt onset of clinically significant obsessions, compulsions, tics, or other neuropsychiatric symptoms or behavioral changes, or a relapsing and remitting course of symptom severity.

PANS means a class of acute-onset obsessive compulsive or tic disorders or other behavioral changes presenting in children and adolescents that are not otherwise explained by another known neurologic or medical disorder.

7. **Anesthesia and Hospital Charges for Dental Care** for an Insured Person who is a child under age five; or is severely disabled; or has a medical condition, and who requires hospitalization or general anesthesia for dental care Treatment. Coverage is provided for general anesthesia and Treatment rendered by a Dental Provider for a covered condition, regardless of whether the services are provided in a Hospital or a dental office.

SECTION V - ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If, as the result of a covered Accident, the Insured Person sustains any of the following losses within the time shown in the Schedule of Benefits, We will pay the benefit shown.

Loss of Life The Principal Sum

Loss of hand	One-Half the Principal Sum
Loss of Foot	One-Half the Principal Sum
Loss of either one hand, one foot or sight of one eye.....	One-half the Principal Sum
Loss of more than one of the above losses due to one Accident.....	The Principal Sum

Loss of hand or foot means the complete severance through or above the wrist or ankle joint. Loss of eye means the total permanent loss of sight in the eye. The Principal Sum is the largest amount payable under this benefit for all losses resulting from any one (1) Accident.

SECTION VI - EXCLUSIONS AND LIMITATIONS

Exclusion Disclaimer: Any exclusion in conflict with the Patient Protection and Affordable Care Act or any state-imposed requirements will be administered to comply with the requirements of the federal or state guideline, whichever is more favorable to the Insured Person.

The Certificate does not cover Loss nor provide benefits for any of the following, except as otherwise provided by the benefits of the Certificate and as shown in the Schedule of Benefits.

General Exclusions

- **International Students Only** – expenses incurred within the Insured Person’s Home Country that would be payable or medical Treatment that is available under any governmental or national health plan for which the Insured Person could be eligible.
- Treatment, service or supply which is not Medically Necessary for the diagnosis, care or Treatment of the Sickness or Injury involved.
- Medical services rendered by a provider employed for or contracted with the Policyholder, including team Physicians or trainers, except as specifically provided in the Schedule of Benefits or as part of the Student Health Center benefits provided by this plan.
- Professional services rendered by an Immediate Family Member or anyone who lives with the Insured Person.
- Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services covered by Student Health Fees.
- Any expenses in excess of Usual and Customary Charges except as provided in the Certificate.
- Expenses for a single service that is duplicated by both a certified Nurse midwife and a Physician.
- Loss resulting from war or any act of war sustained while in the armed forces of any country or international authority, whether declared or not.
- Expenses incurred after:
 - The date insurance terminates as to an Insured Person, except as specified in the extension of benefits provision; and
 - The end of the Policy Year specified in the Policy.
- Elective Surgery or Elective Treatment as defined in Section III unless considered a Preventive Service.
- The Insured Person is:
 - committing or attempting to commit a felony, or
 - engaged in an illegal occupation.
- Custodial Care service and supplies. Examples include routine patient care such as changing dressings; administering oral medications; help with walking, grooming, bathing, dressing; and services that can be performed by a person without any medical or paramedical training.
- Charges for hot or cold packs for personal use.
- Services of private duty Nurse except as provided for Registered Nurse Services while confined or Outpatient Private Duty Nursing. This does not apply to a home care nurse or personal care assistant to a ventilator dependent Insured Person in the Insured Person’s home pursuant to Minn. Statute 62A.155.
- Expenses that are not recommended and approved by a Physician. Physician includes a Physician Assistant (PA), or Advanced Practice Nurse Practitioner (APRN), or other health care professional practicing within the scope of

his or her license.

- Experimental or Investigative drugs, devices, Treatments or procedures unless otherwise covered under Covered Clinical Trials. See the Other Services and Supplies section for more information.
- Routine harvesting and storage of stem cells from newborn cord blood, the purchase price of any organ or tissue, donor services if the recipient is not an Insured Person under this plan, or services for or related to the transplantation of animal or artificial organs or tissues.
- Non-chemical addictions such as gambling, spending, shopping, working.
- Outpatient non-physical and/or occupational therapies (art, dance, etc.).
- Modifications made to dwellings.
- General fitness, exercise programs.
- Hypnosis.
- Rolfing.
- Biofeedback.
- Charges incurred for acupuncture, in any form, except as provided under the Acupuncture Expense Benefit.
- Sleep Disorders, except for a sleep study performed in the Insured Person's home, the diagnosis, and Treatment of obstructive sleep apnea.
- Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary because of Injury, infection or disease.
- Conversion Therapy.

Activities Related

- Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.

Weight Management/Reduction

- Weight management. Weight reduction. Nutrition programs. This does not apply to nutritional counseling, or any screening or assessment specifically provided under the Preventive Services or Enteral Formulas and Nutritional Supplements benefits, or medical nutritional therapy for the Treatment of diabetes.
- Treatment for obesity. Surgery for removal of excess skin or fat.

Family Planning

- Infertility Treatment (male or female)-this includes but is not limited to:
 - Procreative counseling;
 - Premarital examinations;
 - Genetic counseling and genetic testing;
 - Impotence, organic or otherwise;
 - Injectable infertility medication, including but not limited to menotropins, hCG and GnRH agonists;
 - In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
 - Costs for an ovum donor or donor sperm;
 - Sperm storage costs;
 - Cryopreservation and storage of embryos;
 - Ovulation induction and monitoring;
 - Artificial insemination;
 - Hysteroscopy, except if the procedure is Medically Necessary for reasons other than infertility;
 - Laparoscopy;
 - Laparotomy;
 - Ovulation predictor kits;
 - Reversal of tubal ligations;
 - Reversal of vasectomies;
 - Costs for and relating to surrogate motherhood if the individual is not an Insured Person under the Policy;
 - Cloning; or

- Medical and surgical procedures that are Experimental or Investigative, unless Our denial is overturned by an External Appeal Agent.
- Elective abortions, except when the life of the Insured Person upon whom the abortion is performed is at stake. Elective abortion means an elective, non-therapeutic, abortion including those resulting from rape or incest.

Vision

- Expenses for radial keratotomy.
- Adult Vision unless specifically provided in the Certificate.
- Charges for office visit exam for the fitting of prescription contact lenses, duplicate spare eyeglasses, lenses or frames, non-prescription lenses or contact lenses that are for cosmetic purposes.

Dental

- Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric and Adult Dental Care Benefit.

Hearing

- Charges for hearing exams, the fitting or repair or replacement of hearing aids except as specifically provided under the Hearing Aids benefit.

Cosmetic

- Treatment of Acne unless Medically Necessary.
- Charges for hair removal unless Medically Necessary Treatment of gender dysphoria; or hair growth.
- Surgery or related services for cosmetic purposes to improve appearance, except as provided under the Reconstructive Surgery benefit, or to restore bodily function or correct deformity resulting from disease, or trauma, or for port-wine stain removal. Emergency Services in connection with emergency complications related to cosmetic surgery are exempt from this exclusion.

Prescription Drugs

- Any drug or medicine which does not, by federal or state law, require a prescription order, i.e., over-the-counter drugs, even if a prescription is written, except as specifically provided under Preventive Services or in the Prescription Drug Benefit section of this Certificate. Insulin and OTC preventive medications required under ACA are exempt from this exclusion;
- Drugs with over-the-counter equivalents except as specifically provided under Preventive Services;
- Allergy sera and extracts administered via injection;
- Vitamins, and minerals, except as specifically provided under Preventive Services;
- Food supplements, dietary supplements; except as specifically provided under Preventive Services and the Enteral Formulas and Nutritional Supplements benefit;
- Cosmetic drugs or medicines including, but not limited to, products that improve the appearance of wrinkles or other skin blemishes, except in relation to the coverage for the elimination or maximum feasible Treatment of an Insured Person's port-wine stain;
- Refills in excess of the number specified or dispensed after 1 year of date of the prescription;
- Drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
- Any drug or medicine purchased after coverage under the Certificate terminates;
- Any drug or medicine consumed or administered at a Physician's office or outpatient Hospital or while Hospital Confined. This does not apply to products (e.g., vaccines) administered at a retail pharmacy;
- If the FDA determines that the drug is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason;
- Prescription digital therapeutics;
- Bulk chemicals;
- Non-insulin syringes, surgical supplies, , except as specifically provided under Diabetic Supplies in the Prescription

Drug Benefit section of the Certificate;

- Repackaged products;
- Any drug or medicine for the purpose of weight control;
- Sexual enhancements drugs;
- Vision correction products.

Third Party Refund:

When:

1. The Insured Person is injured through the act or omission of another person (the "third party"); and
2. Benefits are paid under this Certificate as a result of that Injury,

We are entitled to a refund by the Insured Person of all Certificate benefits paid as a result of the Injury, subject to subtraction for actual monies paid to account for the pro rata share of the Insured Person's costs, disbursements, and reasonable attorney fees, and other expenses incurred in obtaining the recovery from another source, unless We are separately represented by an attorney. Our right to a refund only applies after the Insured Person has received a full recovery from the third party. "Full recovery" does not include payments made by us to or for the benefit of the Insured Person.

If We are separately represented by an attorney, We may enter into an agreement regarding allocation of the costs, disbursements, and reasonable attorney fees and other expenses. If We and the Insured Person cannot reach agreement of allocation, We and the Insured Person shall submit the matter to binding arbitration.

Important Notice Requirement: An Insured Person who makes a claim against a third party for damages that include repayment for medical and medically related expenses incurred for the Insured Person's benefit must provide Us with timely written notice of the pending or potential claim against the third party responsible for the damages.

Professional Sports, Intercollegiate Sports, or Club Sports

Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport for which benefits are paid by another Professional Sports Insurance Program. Any Sports insurance program will be the primary payor and this Plan will be secondary unless coverage under the Sports insurance program is not available or has been exhausted.

Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate or club sports for which benefits are paid by another Sports Accident policy issued to the Policyholder; or for which coverage is provided by the National Collegiate Athletic Association (NCAA), National Association of Intercollegiate Athletic (NAIA) or any other sports association in excess of the benefit amount shown on the Schedule of Benefits per Intercollegiate or club sports Accident. In excess of the benefit amount shown on the Schedule of Benefits Tthe Sports Accident policy/association insurance program will be the primary payor and this Plan will be secondary unless coverage under the Sports Accident policy/association insurance program is not available or has been exhausted.

Coordination Of Benefits

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one (1) Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

DEFINITIONS

1. A Plan is any of the following that provides benefits or services for medical or dental care or Treatment. If separate policies are used to provide coordinated coverage for members of a group, the separate policies are considered parts of the same plan and there is no COB among those separate policies.
 - a. Plan includes: group and nongroup insurance policies, health insuring corporation ("HIC") policies, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care policies, such as skilled nursing care; medical benefits under group or individual automobile policies; and Medicare or any other federal governmental plan, as permitted by law.
 - b. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each Certificate for coverage under a. or b. is a separate Plan. If a Plan has 2 parts and COB rules apply only to 1 of the 2, each of the parts is treated as a separate Plan.

2. This plan means, in a COB provision, the part of the Certificate providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the Certificate providing health care benefits is separate from this plan. A Certificate may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
3. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than 1 Plan.

When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

4. Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging the Insured Person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

- a. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless 1 of the Plans provides coverage for private hospital room expenses.
- b. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of Usual and Customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
- c. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
- d. If a person is covered by 1 Plan that calculates its benefits or services on the basis of Usual and Customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted

with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's Policy permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

- e. The amount of any benefit reduction by the Primary plan because the Insured Person failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, Pre-Certification of admissions, and preferred provider arrangements.
- 5. Closed panel plan is a Plan that provides health care benefits to Insured Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
 - 6. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by 2 or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
- B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the Policyholder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network Provider benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 - 1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, Policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two (2) Plans is reversed so that the Plan covering the person as an employee, member, Policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
 - 2. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
 - a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - i. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
 - ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), We will follow the rules of that plan.
 - b. For a dependent child whose parents are divorced or separated or not living together, whether or not they

have ever been married:

- i. If a court decree states that one (1) of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 - ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
 - iii. If a court decree states that the parents have joint custody without specifying that 1 parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
 - iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - The Plan covering the custodial parent;
 - The Plan covering the spouse of the custodial parent;
 - The Plan covering the non-custodial parent; and then
 - The Plan covering the spouse of the non-custodial parent.
- c. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
 - d. a. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.
b. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.
3. Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
 4. COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
 5. Longer or shorter length of coverage. The Plan that covered the person as an employee, member, Policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
 6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

- A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary

plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

- B. If an Insured Person is enrolled in 2 or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by 1 Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. Our Agent or We may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. Our Agent or We need not tell, or get the consent of, any person to do this unless applicable federal or state law prevents disclosure of the information without the consent of the patient or patient's representative. Each person claiming benefits under This plan must give Our Agent or We any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, Our Agent or We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. Our Agent or We will not have to pay that amount again. The term payment made includes providing benefits in the form of services, in which case payment made means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Our Agent or We is more than it should have paid under this COB provision, it may recover the excess from one (1) or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Insured Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION VII - GENERAL PROVISIONS

Entire Contract Changes

The Policy, this Certificate, including the application, endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in the Policy or Certificate will be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change the Policy or Certificate or waive any of its provisions.

Time Limit on Certain Defenses

After two years from the date of issue of the Policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred or disability commencing after the expiration of such two-year period.

As used in this provision, disability means any condition or characteristic that renders a person a disabled person. A disabled person is any person who (1) has a physical, sensory, or mental impairment which materially limits one or more major life activities; (2) has a record of such an impairment; or (3) is regarded as having such an impairment.

Notice of Claim

Written or electronic notice of a claim must be given to Us within 90 days after the date of Injury or commencement of Sickness covered by this Certificate, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to Our authorized agent, with information sufficient to identify the Insured Person will be deemed notice to Us.

Claim Forms

We, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by Us for filing proofs of Loss. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of Loss requirements by giving Us a written statement of the nature and extent of the Loss within the time limits stated in the Proofs of Loss provision.

Proof of Loss

Written proof of Loss must be furnished to Us or to Our authorized agent within 90 days after the date of such Loss. If it was not reasonably possible to give written proof in the time required, We may not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. The proof required must be given no later than one (1) year from the time specified unless the claimant was legally incapacitated.

Time of Payment

Indemnities payable under this Certificate will be paid immediately upon receipt of due proof of such Loss.

Payment of Claims

Benefits will be paid to the Insured Person. Loss of life benefits, if any, will be payable in accordance with the beneficiary designation in effect at the time of payment. If no such designation or provision is then effective, the benefits will be payable to the Insured Person's estate. Any other accrued indemnities unpaid at the time of the Insured Person's death may, at Our option, be paid either to such beneficiary or to such estate.

If benefits are payable to the Insured Person's estate or to a beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity, up to an amount not exceeding \$1,000.00, to any one relative by blood or connection by marriage to the Insured Person who is deemed by Us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment.

We may pay all or a portion of any indemnities provided for health care services to the provider, unless the Insured Person directs otherwise, in writing, by the time proofs of Loss are filed. We cannot require that the services be rendered by a particular provider.

Assignment

The Insured Person may assign Out-of-Network benefits payable under this Certificate. In-network benefits are billed directly by the provider. We are not bound by an assignment unless it is in writing and until a duplicate of the original assignment has been filed with Us. We assume no responsibility regarding the validity of any assignment or payment made without notice of a prior assignment.

Physical Examination and Autopsy

We, at Our own expense, will have the right and opportunity to examine the person of an individual whose Injury or Sickness is the basis of a claim when and as often as it may reasonably require during the pendency of a claim hereunder. In the case of the Insured Person's death, We may have an autopsy performed unless prohibited by law.

Legal Actions

No action at law or in equity will be brought to recover on this Certificate prior to the expiration of 60 days after written proof of Loss has been furnished in accordance with the requirements of this Certificate. No such action will be brought after the expiration of three years after the time written proof of Loss is required to be furnished.

Illegal Occupation

We shall not be liable for any loss to which a contributing cause was the Insured Persons commission of or attempt to commit a felony or to which a contributing cause was the Insured Persons being engaged in an illegal occupation.

Conformity with State Statutes

Any provision of this Certificate which, on its Effective Date, is in conflict with the statutes of the state in which the Insured Person resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Change of Beneficiary

Unless the Insured Person makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the Insured Person and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this Certificate or to any change of beneficiary or beneficiaries, or to any other changes in this Certificate.

Incontestability

The validity of this Certificate will not be contested after it has been in force for two (2) years from this Certificate Effective Date, except for fraudulent misrepresentations made by the applicant in the application for such policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of such two (2) year period.

Rescission of Coverage

We may rescind the Insured Person's coverage if the Insured Person, or the person seeking coverage on the Insured Person's behalf:

- Performs an act, practice or omission that constitutes fraud; or
- Makes an intentional misrepresentation or omission of material fact.

SECTION VIII - ADDITIONAL PROVISIONS

1. We do not assume any responsibility for the validity of assignment.
2. The Insured Person will have free choice of a legally qualified Physician with the understanding that the Physician-patient relationship will be maintained.
3. Our acknowledgment of the receipt of notice given under this Certificate, or the furnishing of forms for filing proofs of Loss or acceptance of such proof, or the investigation of any claim hereunder will not operate as a waiver of any of Our rights in defense of any claim arising under this Certificate.
4. This Certificate does not affect coverage by Workers' Compensation Insurance.
5. All new persons in the groups or classes eligible to and applying for this insurance will be added in the respective groups or classes in which they are eligible.
6. The insurance of any Insured Person will not be prejudiced by the failure on the part of the Policyholder to transmit reports, pay Premium or comply with any of the provisions of this Certificate when such failure is due to inadvertent error or clerical mistake.
7. All books and records of the Policyholder containing information pertinent to this insurance will be open to examination by Us during the Certificate term and within one year after the termination of this Certificate.
8. Benefits are payable under this Certificate only for those expenses incurred while the Insured Person is covered. No benefits are payable for expenses incurred after the date the Insured Person's insurance terminates, except

as may be provided under an Extension of Benefits.

SECTION IX – COMPLAINTS AND APPEALS PROCEDURES

If the Insured Person has a claim that is denied by Us, the Insured Person has the right to appeal it. The Insured Person's Authorized Representative may act on the Insured Person's behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination.

For purposes of this Section, the following definitions apply:

Adverse Benefit Determination means a decision by Us or Our designee Utilization Review Organization relating to an admission, extension of stay, or health care service that is partially or wholly adverse to the Insured Person, including a decision to deny an admission, extension of stay, or health care service on the basis that it is not Medically Necessary.

Authorized Representative means:

- A person to whom the Insured Person has given express written consent to represent the Insured Person;
- A person authorized by law to provide substituted consent for the Insured Person;
- A family member of the Insured Person's or the Insured Person's treating health care professional when the Insured Person is unable to provide consent;
- A health care professional when the Policy requires that a request for a benefit under the Policy be initiated by the health care professional; or
- In the case of an expedited appeal claim, a health care professional with knowledge of the Insured Person's medical condition.

Complaint is any oral or written expression of dissatisfaction about quality of care or the operation of the plan.

Concurrent claim means a request for a plan benefit(s) by the Insured Person that is for an ongoing course of treatment or services over a period of time or for the number of treatments.

Concurrent review means utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional or other inpatient or outpatient health care setting.

Health care professional means a Physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

Pre-Service claim means the request by the Insured Person for a plan benefit(s) prior to a service being rendered. Some plan benefit(s) may require pre-certification. For services that require pre-certification, please review the Pre-Certification Process provision.

Post-Service claim means any claims for a plan benefit(s) the Insured Person has already received.

Prospective review means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with Our requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

Retrospective review means any review of a request for a benefit after an admission or the provision of a health care service or a course of Treatment has occurred. Retrospective review does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

Expedited appeal request is a request for a plan benefit(s) that, in the opinion of the treating health care professional, could seriously jeopardize the Insured Person's life or health or Insured Person's ability to regain

maximum function if reviewed under a standard appeal time frame.

Utilization review means a set of formal techniques designed to monitor the use of, or evaluate the Medical Necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, Prospective review, second opinion, certification, Concurrent review, case management, discharge planning or Retrospective review.

In the case of an Adverse Benefit Determination involving utilization review, We will designate an appropriate clinical peer(s) of the same or similar specialty as would typically manage the case being reviewed to determine Adverse Benefit Determination. The clinical peer(s) shall not have been involved in the initial Adverse Benefit Determination. We shall ensure that the individuals reviewing the Adverse Benefit Determination have appropriate expertise.

Utilization Review Organization means an entity that conducts utilization review, other than Us performing utilization review for Our own health benefit plans.

There are 3 types of claims: Pre-Service, Concurrent Care, and Post-Service Claims. In addition, certain Pre-Service or Concurrent Care Claims may involve expedited appeal. If the Company makes an Adverse Benefit Determination, then the Insured Person may appeal according to the following steps.

COMPLAINTS

If the Insured Person is dissatisfied with the service(s) they receive from Us or wants to complain about a provider, he or she should call or write Us. The complaint must include a detailed description of the matter and include copies of any records or documents that the Insured Person thinks are relevant to the matter. We will review the information and provide the Insured Person with a written response within 30 calendar days of the receipt of the written Complaint, unless more information is needed and cannot be obtained within this period. The notice of the decision will tell the Insured Person what they need to do to seek an additional review. This time period may be extended up to 14 days due to extenuating circumstances beyond Our control. If an extension is needed, all of the parties involved will be notified. If the oral complaint is not resolved to the Insured Person's satisfaction within 10 calendar days of receipt of the complaint, We will inform the Insured Person that they may submit their Complaint in writing; and We will offer any assistance needed to submit the written Complaint. In addition, We will provide a complaint form to the Insured Person, which must be completed and returned to the Us for further consideration. We will offer to assist the Insured Person in completing this form. We will also offer to complete the complaint form and mail it to the Insured Person for a signature.

At any time, the Insured Person may also file a complaint with the Minnesota Commissioner of Commerce regarding plan benefits, either in writing or by calling (651) 539-1600, or toll-free at 800-657-3602.

NOTIFICATION OF ADVERSE BENEFIT DETERMINATION AND AUTHORIZATION

If the Insured Person's claim is denied, they will receive written notice from Us that their claim is denied (in the case of expedited appeal claims, notice may be oral). The period in which the Insured Person will receive this notice will vary depending on the type of claim. In addition, We may take an extension of time in which to review the Insured Person's claim for reasons beyond Our control. If the reason for the extension is that the Insured Person needs to provide additional information, the Insured Person will be given a certain amount of time in which to obtain the requested information (it will vary depending on the type of claim). The period during which We must make a decision will be suspended until the earlier of the date that the Insured Person provides the information or the end of the applicable information-gathering period.

We may review ongoing inpatient stays based on the severity or complexity of the Insured Person's condition or on necessary treatment or discharge planning activities. Such review will not be consistently conducted on a daily basis.

Pre-Services Claims

A standard review determination on all requests for utilization review will be communicated to the provider and Insured Person within 5 business days after receiving the request, regardless of how the request was received, provided that all information reasonably necessary to make a determination on the request has been made available to Us.

Notification will be provided by telephone, by facsimile to a verified number, or by electronic mail to a secure electronic mailbox to the attending health care professional and Hospital or Physician office as applicable. Written notification will also be sent to the Hospital or Physician office as applicable and attending health care professional if notification occurred by telephone. Notification may be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. Written notification will be sent to the Insured Person and may be sent by United States mail, facsimile to a verified number, or by electronic mail to a secure mailbox. The written notification will include all reasons relied on by Us for the determination and the process for initiating an appeal of the determination. Upon request, We shall provide the provider or the Insured Person with the criteria used to determine the necessity, appropriateness, and efficacy of the health care service and identify the database, professional treatment parameter, or other basis for the criteria. Reasons for an Adverse Benefit Determination may include, among other things, the lack of adequate information to authorize after a reasonable attempt has been made to contact the provider or the Insured person.

When an Adverse Benefit Determination is made, the written notification will inform the Insured Person and the attending health care professional of the right to submit an appeal to the internal appeal process and the procedure for initiating the internal appeal. The written notice shall be provided in a culturally and linguistically appropriate manner consistent with the provisions of the Affordable Care Act.

Post-Service Claims

We will notify the Insured Person in writing of Our decision and the reasons for it as soon as practical but in no case later than 30 days after receipt of a written complaint. If We cannot make a decision within 30 days due to circumstances outside of Our control, We may take up to 14 additional days to notify the Insured Person of Our decision. If We take any additional days beyond the initial 30-day period to make Our decision, We will inform the Insured Person, in advance, of the extension and the reasons for the extension.

If the decision is partially or wholly adverse to the Insured Person, the notification will inform the Insured Person of the right to appeal the decision Our internal appeal process and the procedure for initiating an appeal. The written notice shall be provided in a culturally and linguistically appropriate manner consistent with the provisions of the Affordable Care Act.

Expedited Appeal Claims

An expedited determination will be utilized if the attending health care professional believes that an expedited determination is warranted.

Notification of an expedited determination to authorize or an expedited Adverse Benefit Determination will be provided to the Hospital, the attending health care professional, and the Insured Person as expeditiously as the Insured Person's medical condition requires, but no later than 48 hours and will include at least one business day after the initial request. When an expedited Adverse Benefit Determination is made, We will also notify the Insured Person and the attending health care professional of the right to submit an appeal to the expedited internal appeal and the procedure for initiating an expedited internal appeal. The written notice shall be provided in a culturally and linguistically appropriate manner consistent with the provisions of the Affordable Care Act.

APPEAL OF ADVERSE BENEFIT DETERMINATION

The Insured Person will be allowed to review the information relied upon in the course of the appeal, present evidence and testimony as part of the appeals process, and receive continued coverage pending the outcome of the appeals process.

INTERNAL APPEAL PROCESS

If the Insured Person does not agree with Our decision and wishes to appeal, the Insured Person must file a written appeal with Us at the address below within 180 days after receipt of the Adverse Benefit Determination notification (or oral notice if an expedited appeal request) referenced in Step 1. If the claim involves an expedited appeal, the Insured Person's appeal may be made orally.

The Insured Person should submit any additional information requested in the Adverse Benefit Determination notification (or oral notice if an expedited appeal request) with their appeal. The Insured Person should gather any additional information that is identified in the notice as necessary to perfect their claim and any other information that the Insured Person believes will support their claim.

Appeals should be sent to:
Wellfleet Insurance Company
Attention: Appeals Unit
Wellfleet Group, LLC
P.O. Box 15369
Springfield, MA 01115-5369

The Insured Person also has the right to contact the Commissioner of Commerce or his or her office at any time. The Insured Person may contact the Commissioner of Commerce at the Minnesota Department of Commerce, 85 7th Place East, Suite 280, St. Paul, MN, 55101; (651) 539-1600, or toll-free at (800) 657-3602.

Pre-Services Claims

We will notify in writing the Insured Person and attending health care professional of Our determination on the appeal within 15 days after receipt of the notice of appeal. If We cannot make a determination within 15 days due to circumstances outside Our control, We may take up to 4 additional days to notify the Insured Person and attending health care professional of Our determination. If We take any additional days beyond the initial 15-day period to make Our determination, We will inform the Insured Person and attending health care professional, in advance, of the extension and the reasons for the extension.

If the Adverse Benefit Determination is not reversed on appeal, We will include in Our notification the right to submit the appeal to the external review process and the procedure for initiating an appeal under the external process.

Post-Service Claims

If an Insured Person appeals in writing, We will give the Insured Person written notice of the appeal decision and all key findings within 30 days of Our receipt of the Insured Person's written notice of appeal. If an Insured Person appeals by hearing, We will give the Insured Person written notice of the appeal decision and all key findings within 45 days of Our receipt of the Insured Person's written notice of appeal.

If the appeal decision is partially or wholly adverse to the Insured Person, the notice will advise the Insured Person of the right to submit the appeal decision to the external review process and the procedure for initiating the external process.

Expedited Appeal

When an Adverse Benefit Determination for a health care service is made prior to or during an ongoing service requiring review and the attending health care professional believes that the determination warrants an expedited appeal, We will ensure that the Insured Person and the attending health care professional have an opportunity to appeal the determination over the telephone on an expedited basis. In such an appeal, We will ensure reasonable access to Our consulting Physician or health care provider.

We will notify the Insured Person and attending health care professional by telephone of Our determination on the expedited appeal as expeditiously as the Insured Person's medical condition requires, but no later than 72 hours after receiving the expedited appeal.

If the Adverse Benefit Determination is not reversed through the expedited appeal, We will include in Our notification the right to submit the appeal to the external appeal process and the procedure for initiating the process. This information will be provided in writing to the Insured Person and the attending health care professional as soon as practical.

In the event the Insured Person disagrees with Our internal review determination, the Insured Person may file a complaint with the Commissioner of Commerce at the Minnesota Department of Commerce, 85 7th Place East, Suite 280, St. Paul, MN, 55101; (651) 539-1600, or toll-free at (800) 657-3602.

EXTERNAL APPEAL PROCESS

If the Insured Person's appeal is denied based on medical judgement such as Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or Treatment and the Insured Person wishes to seek an external review from an external review entity, the Insured Person must file a written request for external review of the Adverse Benefit Determination to the Commissioner of Commerce.

The Insured Person may also seek an external review by an external review entity for a denial of an expedited appeal request based on medical judgement provided that (1) the Insured Person has also filed an internal appeal in accordance with the terms described herein; and (2) the time frames for completion of an expedited appeal will seriously jeopardize the Insured Person's life or health or would seriously jeopardize the Insured Person's ability to regain maximum function.

Standard External Review

Within 6 months after the date of receipt of a notice of an Adverse Benefit Determination, the Insured Person may file a request for an external review with the Commissioner of Commerce.

In most cases, the Insured Person should complete Our Internal Appeals process before they file a request for an external review with the Commissioner of Commerce.

The Insured Person may submit a written request for an external review to the Commissioner of Commerce at the address below:

Minnesota Department of Commerce
85 7th Place East, Suite 280
St. Paul, MN 55101-2198
(651) 539-1600, or toll-free at (800) 657-3602

This written request must be accompanied by a \$25 filing fee. This fee may be waived by the Commissioner in cases of financial hardship. We must participate in this external review and must pay the cost of the review which exceeds the \$25 filing fee. If the Adverse Benefit Determination is completely reversed, the filing fee will be refunded. Filing fees are limited to \$75 in a policy year.

Upon receiving a request for an external review, the Commissioner of Commerce shall assign an external review entity on a random basis. The assigned external review entity will provide immediate notice of the review to the Insured Person and Us. Within 10 business days of receiving notice of the review, the Insured Person and We must provide the assigned external review entity with any information that the Insured Person and We want considered. Each party shall be provided an opportunity to present its version of the facts and arguments. The assigned external review entity must furnish to Us any additional information submitted by the Insured Person within one business day of receipt. The Insured Person may be assisted or represented by a person of the Insured Person's choice.

As part of the external review process, any aspect of an external review involving a medical determination must be performed by a health care professional with expertise in the medical issue being reviewed.

An external review shall be made as soon as practical but in no case later than 45 days after receiving the request for an external review and the external review entity must promptly send written notice of the decision and the reasons for it to the Insured Person, Us, and the Commissioner of Commerce who is responsible for regulating Us.

The Commissioner of Commerce will not afford the Insured Person an external review if:

- a. The Commissioner of Commerce has determined that the health care service is not covered under the terms of Our Policy; or
- b. The Insured Person has failed to exhaust Our internal review process, unless an exception to the exhaustion requirement applies; or
- c. The Insured Person was previously afforded an external review for the same denial of coverage and no new clinical information has been submitted to Us.

Expedited External Review

An expedited external review must be provided if the Insured Person requests it after receiving:

- a. an Adverse Benefit Determination that involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the Insured Person or would jeopardize the Insured Person's ability to regain maximum function and the Insured Person has simultaneously requested an expedited internal appeal;
- b. an Adverse Benefit Determination that concerns an admission, availability of care, continued stay, or health care service for which the Insured Person received Emergency Services but has not been discharged from a facility; or
- c. an Adverse Benefit Determination that involves a medical condition for which the standard external review time would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function.

The external review entity must make its expedited determination to uphold or reverse the Adverse Benefit Determination as expeditiously as possible but within no more than 72 hours after the receipt of the request for expedited review and notify the Insured Person and Us of the determination.

If the external review entity's notification is not in writing, the external review entity must provide written confirmation of the determination within 48 hours of the notification.

IMPORTANT INFORMATION

- Each level of appeal will be independent from the previous level (i.e., the same person(s) involved in a prior level of appeal will not be involved in the appeal).
- The claims reviewer will review relevant information that the Insured Person submits even if it is new information. In addition, the Insured Person has the right to request documents or other records relevant to their claim.
- If a claim involves medical judgement, then the claims reviewer will consult with an independent health care professional that has expertise in the specific area involving medical judgment.

- The Insured Person may review the claim file and present evidence and testimony at each state of the appeals process.
- The Insured Person may request, free of charge, any new or additional evidence considered, relied upon, or generated by Us in connection with their claim.
- If a decision is made based on new or additional rationale, the Insured Person will be provided with the rationale and be given a reasonable opportunity to respond before a final decision is made.
- If the Insured Person wishes to submit relevant documentation to be considered in reviewing their claim for appeal, it must be submitted with their claim and/or appeal.
- The Insured Person should raise all issues that the Insured Person wishes to appeal during Our Internal Appeal process and during the External Review.

CONTACT INFORMATION

If the Insured Person has any questions or concerns, the Insured Person can contact Us at:

Wellfleet Insurance Company
 Attention: Appeals Unit
 Wellfleet Group, LLC
 P.O. Box 15369
 Springfield, MA 01115-5369

Minnesota Department of Commerce
 Main Office, Golden Rule Building
 85 7th Place East, Suite 280
 Saint Paul, MN 55101
 (651) 539-1600 (Local)
 (800) 657-3602 (Greater MN only)

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

Effective: August 01, 2019

This Notice of Privacy Practices (“ Notice”) applies to **Wellfleet Insurance Company** and **Wellfleet New York Insurance Company’s** (together, “ we”, “us” or “ our”) insured health benefits plans. We are required to provide you with this Notice.

Personal Information is information that identifies you as an individual, such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic, and that we obtain so we can provide you with insurance coverage.

Protected Health Information (your “Health Information”) is information that identifies you as related to your physical or mental health, your health care, or payment for your healthcare.

Our Responsibilities

We are required by law to maintain the privacy of the Health Information we hold and to provide you with this Notice and to follow the duties and privacy practices described in this Notice. We are required to abide by the terms of this Notice currently in effect.

We utilize administrative, technical, and physical safeguards to protect your information against unauthorized access and against threats and hazards to its security and integrity. We comply with all applicable state and federal rules pertaining to the security and confidentiality of your information.

We will promptly inform you if a breach has occurred that may have compromised the privacy or security of your Health Information.

Overview of this Notice

This Notice describes how certain information about you may be used and disclosed and how you can get access to this information. This Notice addresses three primary areas:

- An overview of Your Health Information. This section addresses how we collect your information, how we use it to run our business, and the reasons we share it.
- Your Rights. This section gives an overview of the rights you have with respect to your information we have in our records.
- How to Contact Us. In case you have any questions, requests, or even if you feel you need to make a complaint, we want to make sure you are in contact with the right person.

YOUR HEALTH INFORMATION

How We Acquire Your Information

In order to provide you with insurance coverage, we need Personal Information about you. We gather this information from a variety of sources including your employer, your health care provider, your school, other insurers, and third party administrators (TPAs). This information is necessary to properly administer your health plan benefits.

How We use Your Health Information

Below are some examples of how we use and disclose your Health Information. Broadly, we will use and disclose your Health Information for Treatment, Payment and Health Care Operations.

Treatment refers to the health care treatment you receive. We do not provide treatment, but we may disclose certain information to doctors, dentists, pharmacies, hospitals, and other health care providers who will take care of you. For example, a doctor may send us information about your diagnosis and treatment so we can develop a health care plan and arrange additional services.

Payment refers to activities involving the collection of premiums, payment of claims, and determining covered services. For example, we may review your Health Information to determine if a particular treatment is medically necessary and what that payment for the services should be.

Health Care Operations refers to the business functions necessary for us to operate, such as audits, complaints responses and quality assurance activities. For example, we would use your Health Information (but not genetic information) for underwriting and calculating rates, or we may use your Health Information to detect and investigate fraud.

Additionally:

- We may **confirm enrollment** in the health plan with the appropriate party.
- If you are a **dependent** of someone on the plan, we may disclose certain information to the plan's subscriber, such as an explanation of benefits for a service you may have received.
- We may share enrollment information, payment information, or other Health Information in order to coordinate treatment or other services you may need.

We may disclose your information when instructed to do so, including:

- **Health oversight activities** may require that we disclose your information to governmental, licensing, auditing and accrediting agencies;
- **Legal proceedings** may require disclosure of your Health Information in response to a court order or administrative order, or in response to a subpoena, discovery request, warrant, summons, or other valid process;
- **Law enforcement activities** might require disclosure of certain Health Information to local, state or federal law enforcement, so long as the release is authorized or required by law;
- **As required by law** or to avert a serious threat to safety or health; and,
- To **certain government agencies**, such as the Department of health and Human Services or the Office of Civil Rights if they are conducting an investigation or audit.

Authorizations

Occasionally we may receive a request to share your information in a manner outside of how we normally use your Health Information, as described above. In those cases, we will ask you for your authorization before we share your Health Information.

YOUR RIGHTS

You have the **right to request restrictions** on certain uses and disclosures of your Health Information, including the uses and disclosures listed in this Notice and disclosures permitted by law. You also have the **right to request that we communicate with you in certain ways**.

- We will accommodate reasonable requests;
- We are not required to agree to a request to restrict a disclosure unless you have paid for the cost of the health care item or service in full (i.e., the entire sum for the procedure performed) and disclosure is not otherwise required by law; and,
- If you are a minor, depending on the state you reside in, you may have the right in certain circumstances to block parental access to your Health Information. For example, a minor may have the rights of an adult with respect to diagnosis and care of conditions such as STDs, drug dependency, and pregnancy.

You have the **right to inspect and copy your Health Information** in our records. Please note that there are exceptions to this, such as:

- Psychotherapy notes;
- Information compiled in reasonable anticipation, or for use in, a civil, criminal or administrative action or proceeding;
- Health Information that is subject to a law prohibiting access to that information; or,
- If the Health Information was obtained from someone other than us under a promise of confidentiality and the access request would be reasonably likely to reveal the source of the information.

We may deny your request to inspect and copy your Health Information if:

- A licensed health care professional has determined your requested access is reasonably likely to endanger your life or physical safety of another;
- The Health Information makes reference to another person and a licensed health care professional has determined that access requested is reasonably likely to cause substantial harm to another; or,
- A licensed health care professional has determined that access requested by your personal representative is likely to cause substantial harm to you or another person.

You have the **right to request an amendment** to your Health Information if you believe the information we have on file is incomplete or inaccurate. Your request must be in writing and must include the reason for the request. If we deny your request, you may file a written statement of disagreement.

You have the right to know who we have provided your information to -- this is known as an **accounting of disclosures**. A request for an accounting of disclosures must be submitted in writing to the address below. The accounting will not include disclosures made for treatment, payment, health care operations, for law enforcement purposes, or as otherwise permitted or required by law. If you request an accounting of disclosures more than once in a twelve (12) month period we may charge a reasonable fee to process, compile and deliver the information to you this second time.

You have a **right to receive a paper copy of this Notice**. Simply call the customer service line indicated on your ID card and request a paper copy be mailed to you. You may also submit a written request to us at the address below.

You will receive a notice of a breach of your Health Information. You have the **right to be notified of a breach** of unsecure Health Information.

Finally, you have the **right to file a complaint** if you feel your privacy rights were violated. You may also file a complaint with the Secretary of Health and Human Services.

CONTACT

For all inquiries, requests and complaints, please contact:

Privacy and Security Officer
Wellfleet Insurance Company/
Wellfleet New York Insurance Company
c/o Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369

In California
c/o Wellfleet Group, LLC
dba Wellfleet Administrators, LLC
PO Box 15369
Springfield, MA 01115-5369

This Notice is Subject to Change

We may change the terms of this notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all of your Health Information we maintain, as well as any information we may receive or maintain in the future.

Please note that we do not destroy your Health Information when you terminate your coverage with us. It may be necessary to use and disclose this information for the purposes described above even after our coverage terminates, although policies and procedures will remain in place to protect against inappropriate use and disclosure.

Gramm-Leach-Bliley (“GLB”) Privacy Notice

We understand your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of *nonpublic personal information* (“NPI”). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

COLLECTING YOUR INFORMATION

We collect NPI about our customers to provide them with insurance products and services. This may include your name, Social Security number, telephone number, address, date of birth, gender, work/school enrollment history, and health history. We may receive NPI from your completing the following forms:

- Claims forms
- Enrollment forms
- Beneficiary designation/Assignment forms
- Any other forms necessary to effectuate coverage, administer coverage, or administer and pay your claims

We also collect information from others that is necessary for us to properly process a claim, underwrite coverage, or to otherwise complete a transaction requested by a customer, policyholder or contract holder.

SHARING YOUR INFORMATION

We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization such as a policyholder’s or contract holder’s broker, a third-party administrator, reinsurer, employer, school, or plan sponsor. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

We do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

HEALTH INFORMATION

We will not share any of your protected health information (“PHI”) unless allowed by law, and/or you have provided us with the appropriate authorization. Additional information on how we protect your PHI can be found in the Notice of Privacy Practices.

SAFEGUARDING YOUR INFORMATION

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees or authorized individuals who need to know the NPI to provide insurance products or services to you. Our employees are continually trained on how to keep information safe.

ACCESSING YOUR INFORMATION

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our processing costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

CORRECTING YOUR INFORMATION

If you believe the NPI we have about you is incorrect, please write to us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two (2) years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two (2) years.

CONTACTING US

If there are any questions concerning this notice, please feel free to write us at:

Privacy and Security Officer
Wellfleet Insurance Company
c/o Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369

In California
c/o Wellfleet Group, LLC
dba Wellfleet Administrators, LLC
PO Box 15369
Springfield, MA 01115-5369

NOTICE OF NON-DISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

The Company complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Company does not exclude people or treat them worse because of their race, color, national origin, age, disability, or sex.

The Company provides free aids and services to people with disabilities to communicate effectively with us, such as:

1. Qualified sign language interpreters
2. Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose first language is not English when needed to communicate effectively with us, such as:

1. Interpreters
2. information translated into other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Wellfleet Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator,
PO Box 15369
Springfield, MA 01115-5369
(413) 733-4540
civilcoordinator@wellfleetinsurance.com

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
800-868-1019; 800-537-7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ADVISORY NOTICE TO POLICYHOLDERS

U.S. TREASURY DEPARTMENT'S OFFICE OF FOREIGN ASSETS CONTROL ("OFAC")

No coverage is provided by this Policyholder Notice nor can it be construed to replace any provisions of your policy. You should read your policy and review your Declarations page for complete information on the coverages you are provided.

This Policyholder Notice provides information concerning possible impact on your insurance coverage due to the directives issued by OFAC and possibly by the U.S. Department of State. **Please read this Policyholder Notice carefully.**

OFAC of the U.S. Department of Treasury administers and enforces economic and trade sanctions policy on Presidential declarations of "National Emergency". OFAC has identified and listed numerous:

- Foreign agents;
- Front organizations;
- Terrorists;
- Terrorist organizations; and
- Narcotics traffickers

as *Specially Designated Nationals* and *Blocked Persons*. This list can be found on the U.S. Department of Treasury's website (www.treas.gov/ofac)

In accordance with OFAC regulations, or any applicable regulation promulgated by the U.S. Department of State, if it is determined that you or another insured, or any person or entity claiming the benefits of this insurance has violated U.S. sanctions law or is identified by OFAC as a *Specially Designated National* or *Blocked Person*, this insurance will be considered a blocked or frozen contract and all provisions of this insurance will be immediately subject to OFAC. When an insurance policy is considered to be such a blocked or frozen contract, neither payments nor premium refunds may be made without authorization from OFAC. Other limitations on the premiums and payments also apply.

Women's Health & Cancer Rights Act

If you have had or are going to have a Mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). If you are receiving Mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and patient for:

- a. Reconstruction of the breast on which the Mastectomy was performed;
- b. Reconstruction of the other breast to produce a symmetrical appearance;
- c. Prosthesis;
- d. Treatment of physical complications from all stages of Mastectomy, including lymphedemas.

Coverage will be subject to the same plan limitations, copays, deductible and coinsurance provisions that currently apply to Mastectomy coverage and will be provided in consultation with you and your attending physician.

LANGUAGE ASSISTANCE PROGRAM

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call (877) 657-5030.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al (877) 657-5030.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請致電：(877) 657-5030.

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi (877) 657-5030.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. (877) 657-5030번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa (877) 657-5030.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру (877) 657-5030.

میںینت: اذانتک ثدحتت **تعبیر عطا (Arabic)**، نإفاتامدخ ددعاسملا تیوغللا تیناجملا تحاتمك. عاجرلا لاصتلاً ب (877) 657-5030.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan (877) 657-5030.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le (877) 657-5030.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer (877) 657-5030.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para (877) 657-5030.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero (877) 657-5030.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie (877) 657-5030 an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。(877) 657-5030 にお電話ください。

ی سراف امشد نابز رگا: مجوت (**Farsi**) دشاب می مامشد رایتخا رد نابز روط می نابز دادما تامدخ، تسا. (877) 657-5030 تمسا بیگرید.

कृपा ध्या दः यद आप हंद (Hindi) भाषी ह तो आपके लए भाषा सहायता सेवाएं: शुल् उपलब् ह। कृपा पर काल कर (877) 657-5030

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau (877) 657-5030.

ប្រយ័ត្ន: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ(**Khmer**) សេវាកម្មភាសាជំនួយឥតគិតថ្លៃមានសម្រាប់អ្នក។
សូមទូរស័ព្ទមកលេខ (877) 657-5030 ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti (877) 657-5030.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jííł'eh, bee ná'ahóót'i'. T'áá shoodí kohjì' (877) 657-5030 hodiilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac (877) 657-5030

ગુજરાતી (Gujarati) યુ ના: જો તમે જરાતી બોલતા હો, તો િન:દુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છે. ફોન કરો (877) 657-5030

λληνικά (Greek)ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε (877) 657-5030

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (877) 657-5030

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደው(877) 657-5030

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ (877) 657-5030

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ (877) 657-5030

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, **SUBJECT TO LIMITS AND EXCLUSIONS**, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

**Minnesota Life & Health Insurance Guaranty Association
4760 White Bear Parkway
Suite 101
White Bear, Minnesota 55110
(651)-407-3149**

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to \$500,000. Subject to this \$500,000 limit, the guaranty association will pay up to \$500,000 in life insurance death benefits, \$130,000 in net cash surrender and net cash withdrawal values for life insurance, \$500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, \$250,000 in annuity net cash surrender and net cash withdrawal values, \$410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be \$500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to \$250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than \$10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed \$10,000,000, the \$10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the Guaranty Association's limits you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OFFINANCIAL PROBLEMS. ALL LIFE, ANNUITY AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.